Ontario. Royal commission to investigate allegations relating to coroner's inquests.

Report. 1968.

ONTARIO

REPORT

of

THE ROYAL COMMISSION

to

INVESTIGATE ALLEGATIONS RELATING TO CORONERS' INQUESTS

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PRINTED AND BOUND IN CANADA

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PROVINCE OF ONTARIO

(Seal)

ELIZABETH THE SECOND, by the Grace of God of the United Kingdom, Canada and Her other Realms and Territories Queen, Head of the Commonwealth, Defender of the Faith.

TO THE HONOURABLE WILLIAM DICKENS PARKER, a Justice of Our Supreme Court of Ontario

GREETING:

WHEREAS in and by Chapter 323 of The Revised Statutes of Ontario, 1960, entitled "The Public Inquiries Act", it is enacted that whenever Our Lieutenant Governor in Council deems it expedient to cause inquiry to be made concerning any matter connected with or affecting the good government of Ontario or the conduct of any part of the public business thereof, or of the administration of justice therein, and such inquiry is not regulated by any special law, he may, by Commission, appoint one or more persons to conduct such inquiry and may confer the power of summoning any person and requiring him to give evidence on oath and to produce such documents and things as the Commissioner or Commissioners deem requisite for the full investigation of the matters into which he or they are appointed to examine;

AND WHEREAS Our Lieutenant Governor in Council of Our Province of Ontario deems it expedient to cause inquiry to be made concerning the matters hereinafter mentioned;

NOW KNOW YE that We, having and reposing full trust and confidence in you the said William Dickens Parker, a Justice of Our Supreme Court of Ontario, DO HEREBY APPOINT you to be Our Commissioner to,—

inquire into and report upon allegations made by Doctor Morton P. Shulman, of the Municipality of Metropolitan Toronto, that the Government of Ontario and certain senior civil servants of the Department of the Attorney General for Ontario, or any of them:

(a) unlawfully or improperly
  (*i*) suppressed investigations or inquests,
  (*ii*) interfered with investigations or inquests,

(*iii*) suppressed evidence relating to investigations or inquests conducted in the office of the Chief Coroner for Metropolitan Toronto during the period when Doctor Shulman served as the Chief Coroner;

(b) discriminated against persons in relation to their appointment as coroners on the basis of race, creed, colour, nationality, ancestry or place of origin, and

(c) wasted public funds by improper administration under the amendments in relation to the Schedule of Fees and the provisions of Section 21 of The Coroners Act, Revised Statutes of Ontario, 1960, Chapter 69;

And We Do Hereby Confer on you, Our said Commissioner, the power to summon any person and require him to give evidence on oath and to produce such documents and things as you Our said Commissioner deem requisite for the full investigation of the matters into which you are appointed to examine.

And We Do Hereby Further Order that all Our Departments, Boards, Commissions, Agencies and Committees shall assist you, Our said Commissioner, to the fullest extent, and that in order to carry out your duties and functions, you shall have the authority to engage such counsel, research and other staff and technical advisers as you deem proper.

To Have, Hold And Enjoy the said Office and authority of Commissioner for and during the pleasure of Our Lieutenant Governor in Council for Our Province of Ontario.

In Testimony Whereof we have caused these Our Letters to be made Patent, and the Great Seal of Our Province of Ontario to be hereunto affixed.

WITNESS: The Honourable William Earl Rowe,

A Member of Our Privy Council for Canada,
Doctor of Laws, Doctor of Social Science,

Lieutenant Governor of Our Province of Ontario

at Our City of Toronto in Our said Province this thirteenth day of April in the year of Our Lord one thousand nine hundred and sixty-seven and in the sixteenth year of Our Reign.

BY COMMAND

Robert Welch

Robert Welch
Provincial Secretary

PROVINCE OF ONTARIO

(Seal)

ELIZABETH THE SECOND, by the Grace of God of the United Kingdom, Canada and Her other Realms and Territories Queen, Head of the Commonwealth, Defender of the Faith.

TO THE HONOURABLE WILLIAM DICKENS PARKER, a Justice of Our Supreme Court of Ontario

GREETING:

WHEREAS in and by Chapter 323 of The Revised Statutes of Ontario, 1960, entitled "The Public Inquiries Act", a Proclamation was issued appointing you, William Dickens Parker, a Justice of Our Supreme Court of Ontario, to inquire into certain allegations made by Doctor Morton P. Shulman;

WE DO NOW ORDER that clause (a) of the said Proclamation shall be amended by the addition of a new clause entitled clause (aa) as follows:

(aa) unlawfully or improperly

(*i*) suppressed investigations or inquests,

(*ii*) interfered with investigations or inquests,

(*iii*) suppressed evidence relating to investigations or inquests in relation to the deaths of the following persons:

(1) Pearl Gray, who died at Toronto on November 27, 1963,

(2) Barbara Moore, who died at Pembroke on October 10, 1961,

(3) Edith Somordolea, who died at Hamilton on October 1, 1964,

(4) A. N. Magee, who died at Brantford on October 2, 1966.

IN TESTIMONY WHEREOF We have caused these Our Letters to be made Patent, and the Great Seal of Our Province of Ontario to be hereunto affixed.

WITNESS: The Honourable William Earl Rowe,

A Member of Our Privy Council for Canada,
Doctor of Laws, Doctor of Social Science,

Lieutenant Governor of Our Province of Ontario

at Our City of Toronto in Our said Province this ninth day of May, in the year of Our Lord one thousand nine hundred and sixty-seven and in the sixteenth year of Our Reign.

BY COMMAND

Robert Welch

Robert Welch
Provincial Secretary

TO HIS HONOUR THE HONOURABLE WILLIAM EARL ROWE, P.C., LL.D., THE LIEUTENANT-GOVERNOR OF ONTARIO

Sir:

I have the honour to submit my Report as Commissioner appointed by Order in Council under date of 13th April 1967.

I have the honour to be,

Sir,

Your obedient servant,

WILLIAM D. PARKER
Commissioner

ONTARIO ROYAL COMMISSION
ON
CORONERS' INQUESTS

TABLE OF CONTENTS

FOREWORD

Under Terms of Reference set out in an Order-in-Council dated April 13, 1967, this Commission was required

> "to inquire into and report upon allegations made by Doctor Morton P. Shulman, of the Municipality of Metropolitan Toronto, that the Government of Ontario and certain senior civil servants of the Department of the Attorney General for Ontario, or any of them:
>
> (a) unlawfully or improperly
>
> (*i*) suppressed investigations or inquests,
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> (*ii*) interfered with investigations or inquests,
>
> (*iii*) suppressed evidence relating to investigations or inquests
>
> conducted in the office of the Chief Coroner for Metropolitan Toronto during the period when Doctor Shulman served as the Chief Coroner;
>
> (b) discriminated against persons in relation to their appointment as coroners on the basis of race, creed, colour, nationality, ancestry or place of origin, and
>
> (c) wasted public funds by improper administration under the amendments in relation to the Schedule of Fees and the provisions of Section 21 of The Coroners Act, R.S.O. 1960, Chapter 69."

After the Commission was appointed, Dr. Shulman referred to cases which did not fall within the Terms of Reference. As a result the Terms of Reference were enlarged so that I might inquire into them. An Order-in-Council dated May 9, 1967, amended clause (a) by adding clause (aa), as follows:

> (aa) unlawfully or improperly
>
> (*i*) suppressed investigations or inquests,
>
> (*ii*) interfered with investigations or inquests,
>
> (*iii*) suppressed evidence relating to investigations or inquests
>
> in relation to the deaths of the following persons:
>
> (1) Pearl Gray, who died at Toronto on November 27, 1963
>
> (2) Barbara Moore, who died at Pembroke on October 10, 1961,
>
> (3) Edith Somordolea, who died at Hamilton on October 1, 1964,
>
> (4) A. N. Magee, who died at Brantford on October 2, 1966."

In addition, certain statements made by Dr. Shulman after his discharge from office which related to investigations or inquests conducted during the term that he held office were inquired into by me.

Because of the numerous allegations made by Dr. Shulman and the number of matters that had to be inquired into, and because the allegations were of a serious nature touching men in public office, I concluded that the fairest manner in which these allegations could be examined was to deal with each of them separately so that the persons against whom the allegations were made would have an opportunity of hearing those allegations and replying thereto, and Commission Counsel would be in a position to call all persons who had any information touching on the allegations.

OFFICE FILES

Dr. Morton P. Shulman was appointed as Chief Coroner for the Municipality of Metropolitan Toronto by Order-in-Council dated March 7, 1963. He was removed as Chief Coroner by Order-in-Council dated April 6, effective April 7, 1967.

The next day Dr. Shulman removed some 31 files from the office of the Chief Coroner of Metropolitan Toronto which substantially related to investigations and inquests conducted in the office of the Chief Coroner during the period that Dr. Shulman served as Chief Coroner for Metropolitan Toronto.

On April 10, Mr. Hills, Executive Assistant to the Supervising Coroner for Ontario, met Dr. Shulman as he was leaving the Coroners Building on Lombard Street. An altercation arose between them. Several newspapermen were present and as a result remarks allegedly made by Dr. Shulman received wide publicity. According to a report in the *Globe and Mail*, Dr. Shulman is reported to have said about Mr. Hills:

"He is here to take away files to destroy them."

Dr. Shulman admitted making this remark. [Page 34 line 28, to Page 35 line 3]. In the same article he is further quoted as saying:

"I removed them because I feared they would disappear or be destroyed." [Page 36 line 15]

A similar story in the *Telegram* reads:

"Dr. Shulman said he removed the files to insure no effort would be made to destroy them. 'My fears were obviously well-founded because this morning a clerk from Dr. Cotnam's office arrived saying he wanted to remove the files.' " [Page 36 lines 11 to 20]

Although Dr. Shulman at first admitted that he made the quotation, "Mr. Hills is here to take away files to destroy them," he later denied this, saying that Mr. Delaplante, the reporter for the *Globe and Mail*, either misquoted or misinterpreted what he said. Dr. Shulman's version is that he said:

"He is here to take away files. I fear they will be destroyed."

Mr. Delaplante testified that he correctly quoted Dr. Shulman.

As these allegations made by Dr. Shulman were open to the interpretation that the Government of Ontario and certain senior civil servants of the Department of the Attorney General for Ontario, which would include the Supervising Coroner for Ontario, were unlawfully or improperly attempting to suppress evidence relating to investigations or inquests conducted in the office of the Chief Coroner for Metropolitan Toronto during the period when Dr. Shulman served as Coroner, I examined into these allegations and the basis for them.

Mr. John Wagner, Assistant to the Chief Coroner of Metropolitan Toronto, stated that he is normally in charge of the office files. About noon on Saturday, April 8, 1967, he learned that about 31 files which normally are in filing cabinets were missing. Later that same afternoon Dr. Shulman told him that he had removed some personal files from the office. At a later date 31 files were returned by Mr. Elliott Pepper, solicitor for Dr. Shulman. An examination of the files indicated that they were the general correspondence files of the Coroners Office and were not personal to Dr. Shulman. All the correspondence files, including those removed by Dr. Shulman and which were returned by his solicitor, were filed with me, so that no documents from the office of the Chief Coroner had disappeared or were destroyed.

According to Mr. Hills, the firing of Dr. Shulman meant that another coroner would have to be appointed to carry on with the Stern inquest. This meant that the inquest would have to be adjourned and the witnesses notified of the adjournment. Mr. Hills stated that he knew a doctor was coming from Saskatchewan but did not know his name or address. He wished to see the correspondence so that he could secure the doctor's name and address. This was one of the reasons for his attendance at the Coroner's Office. He also wished to make sure that no more files were removed from the morgue, as he had learned the night previously that Dr. Shulman was removing files.

Mr. Hills stated that he had no intention to remove any files. On the contrary it was his intention to protect the remaining files by seeing that no more were removed by Dr. Shulman. [Page 117 lines 1 to 18]. He received no instructions from anyone to remove or destroy files. Dr. Cotnam stated that he did not remove any files from the office of the Coroner for Metropolitan Toronto, nor had he ever destroyed any files which were the property of an office of government, or given any instructions to anyone else to do so. [Page 129 lines 10 to 23].

Dr. Shulman, when called as a witness, stated that his allegations against Mr. Hills and Dr. Cotnam were based on his fear that someone might destroy the files. [Page 38 line 21]. He could not say who was going to destroy these files because he did not know. [Page 49 line 8]. When asked whether he could give one incident where a record was destroyed in his office during the period he was Chief Coroner, he stated that he could give an example of one that disappeared mysteriously. [Page 49 line 17]. The only evidence produced in support of this allegation relates to a 1961 closed file which Dr. Shulman found in 1964 in the basement of the morgue when going through his predecessor's files. It did not relate to any record that was destroyed or disappeared from his office. Although this matter will be dealt with more fully later, I shall attempt to deal at this time only with the alleged document which "mysteriously disappeared".

The file which Dr. Shulman located in the closed files related to an investigation conducted by Dr. Cotnam at Pembroke, Ontario, into the death of Barbara Moore, a three-year-old child who died in the Pembroke General Hospital on October 10, 1961, a few hours after a routine tonsilectomy and adenoidectomy. Following his investigation Dr. Cotnam wrote to Dr. Lawson, the then Supervising Coroner for Ontario, giving particulars and requesting his

advice. Dr. Lawson replied giving his advice. These letters were found by Dr. Shulman. He then telephoned the Crown Attorney at Pembroke, Mr. John Mulcahey, and questioned him about the Barbara Moore case. Mr. Mulcahey looked into the matter and on August 28 called Dr. Shulman back and informed him that no inquest had been held. Dr. Shulman then wrote to Mr. Mulcahey requesting a copy of the coroner's investigation report. On October 13, Mr. Mulcahey wrote to Dr. Shulman as follows:

> "Re: *Barbara Moore, deceased*
>
> I wish to acknowledge receipt of your letter of October 9th, 1964. I am unable to locate my copy of the coroner's investigation report with reference to the above deceased and therefore I am unable to forward the same to you. In view of the fact that this death occurred in the County of Renfrew and at that time Dr. H. B. Cotnam was the Investigating Coroner, I suggest any information pertaining to this occurrence should be obtained from him. I am forwarding a copy of your letter of October 9th to Dr. Cotnam and I am sure if you get in touch with him he will provide you with the information pertaining to this case."

It is the remark, "*I am unable to locate my copy of the coroner's investigation report*", in Mr. Mulcahey's letter with which we are particularly concerned. Mr. Mulcahey stated that Dr. Cotnam reported the death to him by telephone, which was the custom with all coroners. Dr. Cotnam made a further oral report after he discussed the matter with Dr. Lawson, the Supervising Coroner, as to whether an inquest should be held. Mr. Mulcahey did not receive any material in writing from Dr. Cotnam. Counsel for Dr. Shulman relied on this evidence in argument. I am satisfied no written report was ever filed. This was the only evidence put forward by Dr. Shulman of any document that was destroyed or disappeared. He said on oath that he knew of no other document that was missing [Page 71 lines 27 to 30]. There was no evidence that any government official tried to remove or destroy files at any time or that any government document was destroyed or disappeared.

At this time I am not concerned with the reason why Dr. Shulman made these remarks; I am only concerned to determine whether there was any evidence that the Government of Ontario and certain senior civil servants of the Department of the Attorney General for Ontario, which would include the Supervising Coroner for Ontario, were unlawfully or improperly attempting to suppress evidence relating to investigations or inquests conducted in the office of the Chief Coroner for Metropolitan Toronto, during the period when Dr. Shulman served as coroner, by destroying documents or causing them to disappear. No evidence was produced before me that would support the inference that the Government of Ontario and certain senior civil servants of the Department of the Attorney General for Ontario, which would include the Supervising Coroner for Ontario, tried to remove or destroy files at any time.

STERN INQUEST

John David Stern died on March 18, 1967. His body was found under a bridge on the Don Valley Parkway in the City of Toronto. Dr. Shulman investigated the death and determined that an inquest should be held. He set the date for April 11. On Friday, April 7, Dr. Shulman was discharged as Chief Coroner of Metropolitan Toronto but disputed the validity of his dismissal. The following day Dr. Shulman was reported in the Toronto *Telegram* as saying:

> "He was going over transcripts of evidence on Tuesday's inquest and would be there as coroner. . .
>
> "I did not know the Government had anything to *cover up* on this case."

He admitted saying this. [Page 75 lines 2 to 8].

> In the *Globe and Mail* of April 8 it was reported:
>
> "As to the Stern inquest, Dr. Shulman said he was determined to preside over the Stern inquest because it involves a question of L.S.D. and 'I don't want the Government to *sweep it under the rug*.' "

Dr. Shulman admitted making this statement. [Page 75 lines 11 to 18].

> On April 10 he was reported as having said:
>
> "He feels the Provincial Government may *whitewash* the issue." [Page 76 lines 8 to 12]

These are the three statements attributed to Dr. Shulman in relation to the Stern inquest. Each contains an innuendo. The first, that the Government was trying to "cover up"; the second, that it would "sweep under the rug"; the third, that the Government might "whitewash" the issue. Each is an allegation not only of improper conduct, but of illegal conduct. To do any of these things would be to obstruct the course of justice.

During the inquiry into this matter Dr. Shulman was asked whether he felt the Provincial Government might whitewash the issue, and he replied:

> "Because of incidents that occurred that day, sir, I had fears that that would occur. Yes." [Page 77 lines 4 and 5]

Dr. Shulman gave evidence as to "the incidents that occurred that day" on which he based his fears. He stated that on April 7 his assistant, Mr. Wagner, brought him a list of witnesses for the inquest with a summary of their evidence. These sheets form part of the Brief prepared by Detective Sergeant Foster of the Criminal Investigation Branch of the Metropolitan Toronto Police Department, who was in charge of the investigation. Copies of this brief were given to

the Crown Attorney and the Coroner. The following note was attached to the statement of Detective Clifford, one of the witnesses:

> "As to the source of supply to the deceased of L.S.D., this matter is still under under investigation and it would not to be deemed advisable to divulge the results of the investigations to date in this vein for obvious reasons." [Page 164 lines 15 to 19]

Dr. Shulman said in evidence that the reasons were not obvious to him, so he telephoned Detective Sergeant Foster and asked him why there was no evidence as to the source of the L.S.D. [Page 81 lines 21 and 22]. According to Dr. Shulman, Sergeant Foster replied:

> "The inquest should not look into that at all; they should just look into what the person died of and the circumstances preceding it."

Detective Sergeant Foster's evidence as to the notation and the conversation with Dr. Shulman is as follows:

Q. Right. Now, you dictated that—on this document—yourself?

A. I recall typing that on the document myself.

Q. I understand what you say is this question was being investigated by the police—right?

A. That is what I intended.

Q. You did not want any other matter to interfere with the police investigation?

A. That is right, sir.

Q. In doing that were you trying to suppress any evidence or protect people who should be disclosed or not to embarrass anybody because they might be a friend or anything of that nature?

A. Definitely not, sir. I was trying to refrain from hampering the investigation being made by the police at the time, and still continuing to.

Q. Were you ordered by any Government official or anybody from the Department of the Attorney General to prepare that statement?

A. No, sir. The rider on this statement that has been quoted, it was my own doings.

Q. Before putting it there had you discussed the matter with Crown counsel?

A. I had not, sir.

Q. So it was your opinion that the investigation as to source of supply be left with the police officers making their investigation?

A. That is right, sir.

Q. Was there such an investigation taking place?

A. There was and still is.

Q. And what forces are at work on that?

A. The members of the drug squad in the company of the RCMP.

Q. Now, Dr. Shulman said that he read that statement which says "for obvious reasons", and he said it was not very obvious to him and he discussed that with you?

A. Apparently it was not, for he telephoned me at my home.

Q. What was said?

A. Dr. Shulman—first of all he introduced himself on the phone. "Dr. Shulman calling. Sergeant Foster?" "Yes." He said, "I read your brief over," and he said, "I am no wiser than I was before."

Q. Yes?

A. I said, "What do you mean by that, doctor?"
He said, "You don't tell me in the brief here where Stern got the L.S.D. from."

I said, "Well, pardon me, doc, you are the coroner, but from my experience at inquests and 24 years' experience in the police department, I have had numerous inquests in my time, and my understanding is that the purpose of an inquest is to establish where, when, how and by what means the person met their death; in this particular case, John Stern," and I did not feel that the source of the L.S.D. was in fact the issue at that time, and advised him this was being investigated.

Q. Pardon?

A. I advised this avenue of the investigation was being continued.

Q. You advised Dr. Shulman of that?

A. I did, by very competent officers, and it would be continued, and of course I referred them—I advised him at that time it was being investigated by the drug squad in company with the RCMP.

Q. Yes. What did he say as to that?

A. He became quite difficult at that time. He told me that—he said, "Do you mean that is all the witnesses you are calling?"

So I said, "To date that is."

And then he hung up in my ear. [Page 165 line 4 to page 168 line 6]

The two were obviously of different opinions as to whether the source of the L.S.D. was germane to the inquest.

This was the first incident that occurred on April 7 that aroused the suspicion of Dr. Shulman.

Either then or in a subsequent telephone call Dr. Shulman asked Detective Sergeant Foster why the name of a juvenile mentioned in the statement of another witness was not on the list of witnesses. There is a conflict in some respects between the evidence of Dr. Shulman and the evidence of Detective Sergeant Foster regarding what was said at this time. Dr. Shulman's evidence as to what transpired is as follows:

He said, "We have been unable to locate him."

So I said, "Oh, is he not in Toronto?"

"No; he is outside of the city."

I said, "Well, if he is outside of the city and in the province he is still in our jurisdiction. We can subpoena him."

They said, "No; we think he has gone to Montreal."

I said, "Do you have an address in Montreal?"

And he said, "No."

And I said, "Well, have you tried?"

"I have been up to the house a few times and have been unable to locate him." And this was the end of the conversation.

And it just did not ring right. So I phoned back to the police station again and the officer there—or the officer replied. And I said, "I have just been speaking to Sergeant Foster. Would you please look up the index of witnesses?"

He said, "Yes."

I said, "Will you find John Doe and give me his address and phone number?" which he supplied to me.

I then phoned this number. A young man answered. I said, "May I speak to John Doe?"

And he said, "I am speaking."

I said, "I am Dr. Shulman. I am investigating the L.S.D. death of John Stern. I would like to talk to you."

He replied, "You will have to talk to my father."

A man then came on the phone and introduced himself as Mr. Doe. And he said, "We have already given a statement to the police, and I have nothing further to say."

I said, "I would like very much to have the opportunity to speak to you. May I come up to the house?"

And he agreed.

I then, being a little, very disturbed about this and other things, phoned back Sergeant Foster, first attending to the caution of putting someone on the phone in case there would be a question of what was said. And I went over the conversation again, with the one addition of saying, "Do you think that John Doe could be a lead to the source of the L.S.D.?"

And he replied, "Yes, but unfortunately he is in Montreal. We have no way of getting to him."

I then contacted Sergeant Roy Norman at the Coroner's Office attached to the Metropolitan Toronto Police, and I told him there was something very strange occurring in this case—"which apparently involves the police. I am very upset about it and I wish you would make up two subpoenas and subpoena John Doe and Mr. Doe," which we did. (Page 83 line 6 to page 85 line 1)

Detective Sergeant Foster's evidence as to this conversation is as follows:

Q. Prior to that was there any discussion about a witness called Schniffer?

A. No. The doctor phoned me back again.

Q. Yes, I see. All right. And did he discuss with you this question of the witness Schniffer?

A. Yes, and another party; yes.

Q. Yes, all right. Now, as I understand it, Dr. Shulman said this morning that he either paraphrased or read from the brief in which the lad Schniffer testified as to being with some juvenile. Do you recall that? You just testified to that. I just had that read to you.

A. Yes, that sounds familiar; yes.

Q. Yes. And was there then the question then arising about whether this juvenile that Schniffer had mentioned in his evidence was being called as a witness?

A. That is right, sir.

Q. Would you find in the statement of Schniffer this passage?

A. This juvenile in particular, his name is mentioned in different places in Schniffer's statement.

Q. Yes. First of all, was it intended to call Schniffer at the inquest?

A. Definitely, sir.

Q. And was he called?

A. He was, sir.

Q. And did he give his evidence?

A. He did, sir.

Q. I see. To your recollection was there any evidence from him or did he have any knowledge as to the source of the LSD?

A. No, sir.

Q. All right. Now, did he mention a juvenile?

A. He did, sir.

Q. In his statement?

A. Yes, sir.

Q. And did Dr. Shulman mention the juvenile's name to you?

A. He did, sir.

Q. All right. And what did you say? What was the discussion about?

A. I told him that to my information this juvenile in question was presently in Montreal.

Q. Where did you get that information?

A. As a result of an investigation by two detectives I had assigned to investigate that particular aspect of the case.

Q. And what happened after that?

A. I believe he asked for the address.

Q. Yes?

A. Of the boy in question.

Q. Yes?

A. I was at my home, and I told him that it was at the office.

Q. Yes?

A. And he said he would phone the office.

Q. I see. And was he given the address then?

A. I understand he was, sir, yes.

Q. He has testified that he picked up the phone and talked to the juvenile witness on the phone.

A. Quite possibly, sir.

Q. He was there; is that right?

A. He could have.

Q. Well, that is what he said.

A. Yes.

Q. And the witness was apparently subpoenaed. The juvenile we are talking about, do you know who it is?

A. He was not subpoenaed by me.

Q. Dr. Shulman said he subpoenaed him in company with Detective Norman, I think.

DR. SHULMAN: *Sergeant* Norman.

Q. Sergeant Norman. Do you know the name of the juvenile that we are addressing you to?

A. I do, sir.

Q. And do you know yet whether than man was subpoenaed? Dr. Shulman said he and Sergeant Norman subpoenaed him.

A. I am given to understand that he did—that under Mr. Shulman's signature he was subpoenaed.

Q. Yes. Well now——

A. May I add, he did not show up at the inquest.

Q. Well, were you there?

A. I was.

Q. Has he been interviewed; do you know?

A. Yes, sir.

Q. I see. By you, or under your instructions?

A. Under my instructions, sir.

Q. Has he any information as to the source of the L.S.D.?

A. No, sir.

Q. I beg your pardon?

A. No, sir.

Q. How do you account for the fact that you told Dr. Shulman that the witness is in Montreal and he picks up the phone and calls him and he answers the phone, according to Dr. Shulman's evidence?

A. My understanding was that he was in fact in Montreal. It just so happened when Dr. Shulman called him he was home then.

Q. I mean, were you trying to keep this fellow away from the inquest?

A. No, sir.

Q. You knew the name of the juvenile?

A. Yes, sir.

Q. Had you intended to pursue it or, when you found out he was in Montreal, just let it stand?

A. No, sir. I had instructed officers to pursue that particular name in the investigation. And that name was mentioned to him, sir.

Q. And he has been interviewed?

A. Yes. [Page 171 line 2 to page 175 line 3].

Q. Did you have instructions—this juvenile we are talking about; were there ever any instructions directing you not to call this juvenile or interview him?

A. Definitely not, sir. [Page 175 line 27 to page 176 line 1].

As to why he did not put the name of the juvenile on the list of witnesses, Detective Sergeant Foster gave the following explanation when cross-examined by Dr. Shulman:

Q. Thank you. Now, up until the time that I phoned the juvenile and he happened to have returned from Montreal, had he been interviewed by the police?

A. Yes, he was interviewed, I believe, the day—I believe the morning after the fatality, which would be possibly Sunday, March 19th.

Q. Why was he not subpoenaed?

A. Well, he wasn't subpoenaed because it was felt that he had nothing to lend, no evidence that was—I won't say relevant—but nothing further to what we already had from four or five other boys.

Q. Did you know this at the time you spoke to me on the phone?

A. At that time this boy's name was protected as a juvenile—had come up; his name had been mentioned in various avenues in the investigation and at that time I was in fact anxious to have this boy interviewed again.

Q. Again, did you say?

A. Yes.

Q. Now, are you suggesting—correct me if I am wrong—that immediately after this interview the boy left town and you have been unable to hear from him again?

A. I don't know when he left town and I don't know when he come back. All I know is that when officers under my instructions attended his home, only to find out that at that time he was in Montreal.

Q. Would you be very shocked if you were to learn this boy was in Toronto from the day he was first interviewed until the day I subpoenaed him, with the exception of two days?

A. That is possible.

Q. In other words, the police didn't try too hard to find him, did they?

A. There is some 150 witnesses or potential witnesses interviewed in this case. The investigators certainly can't be everywhere at once.

Q. In other words, they didn't try?

A. They did try.

Q. They did try?

A. They had information he was in Montreal.

Q. Where did they get the information he was in Montreal?

A. I don't know. I did assume his home.

Q. They didn't go back a second time?

A. I don't know. I simply assigned two officers to interview this lad and many others, and naturally left it to the investigating officers; quite capable officers. [Page 189 line 13 to page 191 line 10]

No evidence was given to suggest that this was not a reasonable explanation or to show that it was untrue.

Mr. Henry H. Bull, Q.C. has been Crown Attorney for the County of York since 1961, having previously served as an assistant since September 1, 1939.

His office was notified that the Stern inquest was scheduled for April 11. On April 10, having learned that Dr. Shulman had been relieved of his office, he realized that the inquest would be conducted by someone else so got in touch with Detective Sergeant Foster and secured a copy of the brief from him. The notation made by Detective Sergeant Foster as to the source of supply of L.S.D. was drawn to his attention and his evidence as to their discussion reads in part [Page 225 line 12 to page 226 line 11]:

Q. Yes?

A. Well, as I understood it he—perhaps not he personally, because he does not carry on investigations in the drug field directly.

Q. Right.

A. But, as I gathered from Sergeant Foster, those who were concerned—Detective Clifford, the RCMP, and probably others—were concerned with the source of supply not only in this particular case but in trafficking in L.S.D. or other like drugs in Toronto.

Q. Yes?

A. I was concerned myself, having some experience with investigation, that the disclosure of names, the publication of names, would drive possible suspects or persons to be investigated under cover.

Q. Yes.

A. And that therefore this was a very delicate area of investigation in the inquest and it would be preferable, until the police investigations were completed, if they could be completed, that nothing come out at the inquest about this, so that the police investigations should not be obstructed.

These are the two incidents which occurred prior to Dr. Shulman's making his allegations. Dr. Shulman was questioned regarding the conclusions he drew from these incidents [Page 85 line 8 to page 87 line 13]:

Q. Well now, let me see what has been going on so far. You felt that the source of L.S.D. was germane to the inquest?

A. Yes, sir.

Q. And other people did not agree with you apparently at the moment; is that right?

A. Another person did not.

Q. All right. So far as you have talked to Detective Foster?

A. Yes, sir.

Q. And he is a Metropolitan Toronto Police Officer?

A. Yes, sir.

Q. Yes. And is he one of those that you thought wanted to cover up?

A. My impression of Sergeant Foster was that he was under orders, sir.

Q. Why would anybody want to cover up? The words "cover up", I think you will agree with me, have very sinister implications that it is improper. It is not just a difference of opinion. You say "cover up" means to sweep it under the rug and not disclose it for improper reasons?

A. Yes, sir.

Q. All right. Now, were you saying Detective Foster had an improper motive——

A. No, sir. I think he was following orders.

Q. All right. Whose orders do you think he was following?

A. I don't know, sir.

Q. You mentioned Henry Bull.

A. Oh, yes. There was a letter in which he said exactly the same words that Sergeant Foster had used in reference to another case.
May I read it?

Q. Just a moment now.

THE COMMISSIONER: We will get to it.

Q. We will get to it.
So then Henry Bull is of the same opinion?

A. Yes.

Q. He is the chief law enforcement Crown officer in Metropolitan Toronto?

A. Yes, sir.

Q. Now are you suggesting then that he is of this mind that he is trying to cover up, would you say? I want to know what the words "cover up"——

A. It is to prevent things from coming to the attention of the public.

Q. For an improper purpose?

A. For any purpose.

Q. Are you suggesting that it is improper or could there be a difference between the Crown Attorney and a coroner as to who is going to carry out a police investigation?

A. That is not an investigation, sir. It is a matter of prevention of death in future cases.

Q. I want to know now when somebody was of the opinion that the source of the L.S.D. was not germane to the inquest, that you call that a "cover up".

A. No, sir. I call that a suppression of facts.

Q. That would be an *improper suppression of facts*?

A. In my opinion, yes.

It is clear that Dr. Shulman was of opinion that the source of drugs was a subject of inquiry for the Coroner, while the Crown Attorney and the investigating police officer were of the opinion that an investigation into the source of drugs was a matter for the police, and premature inquiry during a coroner's inquest would hamper the police investigation which was already under way. An honest difference of opinion on an issue such as this is understandable. Reasonable men can respect the opinions of others without agreeing with them. A reasonable man, however, does not impute misconduct on the part of others merely because they hold different opinions. For the conduct of the Crown Attorney or police officer to be "improper" in relation to their opinion that a Coroner should not inquire into the source of supply of illegal drugs, it would have to be shown that there was wrongful intent on the part of the police officer or Crown Attorney, that they were trying to suppress evidence for an improper

purpose, for example, to protect a wrongdoer from criminal prosecution. There was no evidence of any kind to suggest this.

Dr. Shulman at the hearing referred to matters which subsequently arose which he felt corroborated his views. These matters could not have influenced his judgment at the time he made the allegations, for they had not yet arisen at that time.

After the dismissal of Dr. Shulman, Dr. Cruickshank, a coroner of thirty-one years standing, was appointed to carry on with the Stern inquest. In his opening remarks to the jury, Dr. Cruickshank said:

> "The purpose of this inquest will be to present evidence which will show when, where, how and by what means the deceased John Stern came to his death." [Page 263 lines 11-14]

After reciting the evidence that would be called, he said:

> "The issue in this case is not where the deceased obtained the drug or whether it was obtained illegally. These are matters for investigation by the police." [Page 264 lines 9-12]

Dr. Shulman disagreed with this portion of the charge and felt that Dr. Cruickshank's action in so charging the jury was improper [Page 93 line 1 to 20].

To Dr. Shulman, Dr. Cruickshank's action in charging the jury as to what was relevant was improper, as it may have kept certain information from being brought out at the inquest.

Dr. Shulman must know that it is not wrong to reject irrelevant evidence. It is proper to exclude it. This should be done at every inquest. So long as the person who makes the ruling holds the honest opinion that the evidence is irrelevant, then there is nothing improper in his so advising the jury. To infer that because evidence is kept from a jury that it must be done improperly, is not only incorrect, it is mischievous.

Dr. Cruickshank stated that before the inquest was held he met with the Crown Attorney and considered whether the jury should inquire into the source of the L.S.D. Mr. Bull advised him that in his opinion this was not relevant and might interfere with investigation by the police. Dr. Cruickshank accepted this advice and agreed with it.

The evidence of Mr. Bull as to the advice given reads [Page 227 line 15 to line 28]:

> Q. Did you give him any advice as to whether, at the hearing, the source of supply should be gone into during the inquest?
>
> A. Yes, I said I didn't think it should be. In my view, we were then proceeding with an inquest to determine the how, where, when, and by what means the deceased had come to his death. It would not make any difference whether he was under the influence of L.S.D., alcohol, or any other drug in order to determine the answer to these questions, and I therefore felt that any exploration into the source of supply was, first of all, irrelevant; and, second of all, could be detrimental to the police investigation. I so advised him and he agreed with me.

Mr. Bull stated that he gave this opinion on his own responsibility as a Crown Attorney.

Dr. Shulman referred to the fact than an eye-witness named was not subpoenaed as a witness until the inquest opened on April 11, and until he pointed out that the witness should be called. This evidence was relied on by Dr. Shulman as supporting his allegation that the Government or senior civil servants improperly or unlawfully were suppressing evidence with respect to the Stern Inquest [Page 91 lines 7 to 23].

Q. We are going to come to that. I want to know now, doctor, what evidence you have and what witnesses you want me to call to support the fact that a Government or senior civil servants improperly or unlawfully were suppressing evidence with respect to the Stern inquest?

A. Sir, in addition to what I have told you, I will go on to say——

Q. So far, we have got Sergeant Foster and he will be called.

A. In addition to what I said I would like to go on to say that subsequently it was discovered there was an eye-witness to this man going off the bridge. At the inquest the Crown Attorney elaborated on the possibility the man might have been hit by a car and this eye-witness had not been subpoenaed to the inquest.

The evidence of Detective Sergeant Foster as to this matter is as follows [Page 175 lines 4 to 26]:

Q. Well now, reading the press—and I was away this weekend, but I noticed a witness' name called O'Brien was referred to?

A. Yes, sir.

Q. Now, I am looking through this. I don't see his name on the witness sheet. When was this prepared, do you recall?

A. This sheet was prepared the week of the 3rd.

Q. The week of April the 3rd?

A. April the 3rd, yes.

Q. What about the witness O'Brien?
What happened to him?

A. I had no personal knowledge of the witness O'Brien at that time, nor until such time as Dr. Shulman mentioned it at the inquest.

Q. And was he subpoenaed?

A. He was, sir.

Q. Pardon?

A. He was, sir.

Q. Was there any intention to withold his testimony that was relevant to the inquest?

A. Definitely not, sir.

And page 183 line 11 to page 185 line 21—on cross examination by Dr. Shulman:

Q. Sergeant Foster, I would like to ask one or two questions. You were in charge of the investigation of the Stern inquest?

A. Right, sir.

Q. You would be aware of all the witnesses?

A. Yes, sir.

Q. You stated—and correct me if I am wrong—that Dave O'Brien had not turned up by April 10th?

A. April 10th? I don't recall making a reference to not turning up April 10th. I didn't know about him.

Q. You didn't know that he was available by April 10th?

A. I didn't know about him personally until you mentioned it at the inquest.

Q. Would it be possible for another officer investigating to have taken a statement and not passed it on to you?

A. That is quite possible.

Q. How could that happen if you are in charge?
Should not a police officer pass information on to you?

A. Yes.

Q. Do you know an Officer Corbett?

A. Yes.

Q. Have you since learned Officer Corbett took a statement from this witness on March 30th?

A. Yes.

Q. Can you give me any explanation as to why you were not notified: why this witness was not subpoenaed?

A. Yes, I can explain that. Officer Corbett took the statement at City Hall. It is what we call a supplementary report to the original report, forwarded through the usual channels, and unfortunately the copy of that particular report that should have reached my hands was filed with the —was mis-filed, let us put it that way—was mis-filed with the other copies that are kept in the file at the office for future reference and for record purposes.

Q. You might say lost?

A. Not lost. It was mis-filed. If that copy had reached my attention, as it should have, Mr. O'Brien would have been subpoenaed. He would have been interviewed and subpoenaed and been there at the inquest.

Q. In other words, there was a foul-up with the report and you didn't learn about it; is that correct?

A. It is human nature. That is what happened.

Q. Is it possible there were other witnesses who made reports that also didn't reach you?

A. No. If the proper supplementary reports were put in—I have since gone back through both files to compare, and to my knowledge I know where all the—

Q. To your knowledge you are aware of all other witnesses; is that what you are saying?

A. That is right.

This oversight on the part of the police might indicate carelessness but without some evidence of intent could hardly be considered suppression of evidence. No evidence was produced to suggest that the oversight was deliberate

or that it was done to protect anyone or to cover up. The witness O'Brien was called and gave evidence at the inquest, so in fact there was no cover-up of his evidence.

Although Dr. Shulman did not suggest that anyone was covering up by not calling Dr. Hoffer as a witness, his counsel in argument suggested that Dr. Shulman's efforts to place all the relevant facts and circumstances before the jury in the Stern case were obstructed by the fact that Dr. Hoffer was not called. Dr. Shulman stated at the hearing that because there was a suggestion that Stern had died while under the influence of L.S.D., he was worried that the hysteria would produce what he called "bad legislation", that is, legislation widely prohibiting the use of L.S.D. Dr. Shulman therefore wished Dr. Abraham Hoffer, a director of research at the University of Saskatchewan, to come to the inquest to advise the jury as to the effects of L.S.D., its dangers and its values, in an attempt to forestall such legislation [page 97 lines 16 and 17].

The appointment of a coroner to replace Dr. Shulman on the Stern inquest required the hearing to be adjourned and witnesses were advised that they would not be required to attend on the date initially set. Although so advised by Sergeant Foster, Dr. Hoffer did attend on April 11 as he was passing through Toronto on his way to New York. His presence was known to Dr. Shulman but not to the coroner, the Crown Attorney or the investigating officer. Mr. Bull stated that had he known Dr. Hoffer was present he would have called him, although it was not his intention to call the medical evidence on that particular evening.

He did not learn that Dr. Hoffer had attended in Toronto until after the inquest was over and the doctor had left. According to Mr. Bull, Dr. Shulman told him Dr. Hoffer had gone to New York at five o'clock that afternoon. Mr. Bull testified that he immediately advised Dr. Cruickshank of this and suggested that a letter be sent to Dr. Hoffer advising him of the adjourned date. Dr. Shulman testified that he told Mr. Bull that Dr. Hoffer was at the Royal York Hotel and that he was leaving the next day for New York. Dr. Cruickshank was not present when Mr. Bull talked to Dr. Shulman, but testified that after the inquest Mr. Bull informed him that Dr. Shulman said that Dr. Hoffer had been in town that afternoon but left at five o'clock for New York. Detective Sergeant Foster testified that he was present for part of the discussion between Mr. Bull and Dr. Shulman and heard Dr. Shulman say, in effect, that Dr. Hoffer was here but had gone [page 182 lines 6-10]. Since Dr. Hoffer was in Toronto, but not at the inquest, the remark that "he had gone" could only mean that he had left Toronto. I do not believe that Dr. Shulman told the Crown Attorney that Dr. Hoffer was leaving the next day for New York. If there was any obstruction in calling Dr. Hoffer, it was not on the part of Mr. Bull. Evidence was given at the inquest by other expert witnesses as to the effects of L.S.D., so there was no suppression of evidence on this point.

Having considered the evidence relating to the two incidents on which Dr. Shulman relied when he made his allegations of "cover up", "sweeping under the rug" and "whitewash", and the evidence in relation to the subsequent

events which he felt corroborated his views, I am satisfied that there was no illegal or improper suppression of relevant evidence relating to this inquest, and no attempt to suppress such evidence. Dr. Shulman was unable to give any possible motive for anyone wanting to cover up this affair [page 92 line 1]. He was unable to give the name of any individual who was going to cover up [page 88 line 7]. There was no evidence before me that any relevant information was not given to the jury. Although Dr. Shulman's suspicions were aroused when a police officer advised him that the investigation into the source of drugs was a matter for the police rather than for the coroner, Dr. Shulman knew that the police officer's opinion as to what was proper procedure was also held by the Crown Attorney, whose duty it was to place all relevant evidence before the Coroner. Because their opinion differed from his hardly justified the suggestion that there was going to be an improper suppression of facts.

The second incident on which Dr. Shulman relied related to the first, namely the source of supply. The pursuit of this juvenile witness by Dr. Shulman indicates that he was determined to pursue the matter of source of supply regardless of the opinion of the investigating police officer or the Crown Attorney, and regardless of the consequences that calling this witness might have on the police investigation. If Sergeant Foster were trying to cover up, would he put a notation on the Coroner's Brief to bring to the attention of the Coroner that this particular phase of the investigation should not be developed?

The two incidents on which Dr. Shulman relied when he made his allegations do not support them. The incidents he refers to as corroboration add nothing. The failure initially to call a witness at the inquest might indicate carelessness, but could hardly be considered an attempt to cover up. The address by Dr. Cruickshank was open and proper. It expressed his opinion as to the purpose of an inquest and as to the relevancy of certain evidence.

No evidence was given before me in relation to this matter on which I could find there was any attempt on the part of any person, or on the part of senior civil servants to cover up, to sweep under the rug or to whitewash.

I therefore find that there was no unlawful or improper suppression of any evidence, or any unlawful or improper interference by any member of the Government or senior official of the Department of the Attorney General, in relation to the death of John David Stern.

GUALTIERI INQUEST

Fire occurred at the Hospital and Rehabilitation Centre of the Workmen's Compensation Board on Friday, March 31, 1967, in the early hours of the morning. The subsequent events in relation to this matter culminated in Dr. Shulman's being relieved of his duties as Chief Coroner of Metropolitan Toronto. Francesco Gualtieri died in the fire. Dr. Eli Cass, who has been a coroner for the past ten years, was assigned to the investigation about 7:30 A.M. on the same morning. He viewed the body and ascertained the circumstances surrounding the death. He decided that an inquest was indicated and discussed the date with Sergeant Norman of the Metropolitan Toronto Police Department, who was attached to the coroner's office. An appointment was set for May 2 at 7:00 A.M. There was no discussion at that time about assembling a jury to view the scene.

Dr. Cotnam, the supervising coroner, attended at the hospital on Saturday, April 1, at approximately 12:30 in the afternoon, accompanied by Mr. Hills, his executive assistant. Dr. Cotnam discussed the fire with Dr. G. Curry, the director of the centre, then visited the dormitory area where the fire had occurred. He was also accompanied at this time by Detective Mullett of the Metropolitan Toronto Police, who was in charge of the investigation. Since workmen were already starting to clean up the area, Dr. Cotnam felt that a jury should be impanelled at once so that they might see the scene before too much change had taken place.

On Monday, April 3, Mr. Hills telephoned Dr. Cass advising him that Dr. Cotnam intended to take over the inquest. Dr. Cass did not object to this as he felt that Dr. Cotnam had a perfect right to do so under the Coroners Act.

Shortly afterwards, Dr. Cass telephoned Dr. Shulman and advised him that Dr. Cotnam was taking over. Dr. Shulman told Dr. Cass that he did not wish him to relinquish the inquest. Dr. Cass told him that under the Act Dr. Cotnam had the right to take over, but Dr. Shulman instructed him to carry on, and indicated that he would send him a letter outlining his reasons and giving his authority. Dr. Shulman later gave him a copy of a letter he sent to the Attorney General, which will be referred to later.

Following his telephone call to Dr. Cass, Mr. Hills telephoned Sergeant Norman, requesting that he assemble a jury for the following night so that they might visit the scene of the fire, and advising him that Dr. Cotnam would be in charge of the inquest. While Mr. Hills was talking to Sergeant Norman, the telephone conversation was interrupted by Mr. Wagner, assistant to the Chief Coroner, who stated that he had received instructions from Dr. Shulman that Dr. Cotnam could not have the facilities of the morgue, nor could he use the personnel to call a jury [page 291 lines 25 to 29].

Sergeant Norman then received a telephone call from Dr. Cass requesting him to assemble a jury as soon as possible to view the scene, and the inquest date was moved forward to April 5.

The jury was assembled on April 5, visited the scene, and the inquest was then adjourned. Dr. Cotnam then got in touch with Dr. Cass and advised him that as the jury had visited the scene, he was satisfied to let Dr. Cass carry on with the inquest.

On April 7 Dr. Shulman was quoted in the *Globe and Mail* as saying:

> "Before we heard from Dr. Cotnam we had already determined that the supposedly fire-proof hospital had been built with a papered ceiling, that the plans had not been submitted to the Fire Marshal's office before building commenced, that the building had not been properly inspected during the eight years it was up, that the patients had been taking night leave and going to a nearby drinking establishment and getting back in the hospital by climbing through windows. At this point the Fire Marshal had been despatched to examine the building and the inquest had been set for Wednesday night. Dr. Cass then received a phone call from Dr. Cotnam's assistant instructing him not to hold the inquest. The implications are obvious." (Page 379 line 22 to page 380 line 22)

Dr. Shulman made similar statements regarding this particular inquest which left no doubt as to the implication he intended. On the same day he appeared on a CBC television program (April 7, 1967, the same day that he was discharged from office) and is reported to have said:

> "I presume the Government will make some effort to make sure that there is a mock inquest conducted by Dr. Cotnam." (Page 391 lines 27-29)

In the *Globe and Mail* of April 8, 1967, Dr. Shulman was quoted as saying:

> "I suppose it will be conducted by Cotnam and that means a whitewash." (Page 396 lines 1-2)

The statement by Dr. Shulman to the press does not truly set forth the facts. At the time Dr. Cass heard from Dr. Cotnam's office on April 3, the inquest had not been set for Wednesday night April 5. It had been set for May 2. This is clear from the evidence of Dr. Cass [page 309 lines 4 to 6]:

Q. Your inquest was still scheduled for May 2nd?

A. That is right.

The evidence of Sergeant Norman, corroborates this. [Page 290 lines 4 to 27]:

Q. Did you receive a telephone call on April 3rd from Mr. Hills of Dr. Cotnam's office?

A. I did, sir.

Q. About what time would that be?

A. It would be somewhere around the noon-hour, sir.

Q. I see.

A. I can't place it any closer than that.

Q. Up to that time the date of the inquest was still May 2nd?

A. That is correct, sir.

Q. Now, would you tell me what transpired at that time with Mr. Hills?

A. Yes, sir.

Q. All right.

A. Mr. Commissioner, I received a call from Mr. Hills, and he requested that I assemble a jury as Dr. Cotnam was now to be in charge of the inquest, and that Dr. Cotnam wished the jury to view the hospital scene, and therefore would I assemble the jury, and that is as far as we got in the conversation.

Mr. Hills' evidence on this point is: [Page 333 line 14—page 334 line 3]:

Q. All right. Was there a decision made that Dr. Cotnam in fact would conduct this inquest?

A. I believe the decision was made on the Monday morning, which would be April 3rd.

Q. April 3rd?

A. Yes.

Q. What did you do about that?

A. I was instructed by Dr. Cotnam to telephone Dr. Cass and to advise him that he, Dr. Cotnam, would be taking over the conduct of the inquest; and further to telephone Sergeant Norman and to attempt to have a jury subpoenaed so we could take them out to view the scene at seven P.M., Tuesday, April 4th.

Q. To that time the only other arrangements were for the jury to be summoned on May 2nd?

A. Yes, sir.

Q. I am sorry—

A. As far as I am concerned.

Dr. Cotnam stated that when he visited the scene of the fire on April 1, he learned that a coroner had been appointed but the date set for the inquest was not until May 2. Since workmen were cleaning up the premises, he felt that a jury should visit the scene at once before any of the evidence was removed. He made this decision on his own. He did not seek instructions from anyone and was carrying out what he felt to be his responsibility. He was not attempting to sweep anything under the rug and it never occurred to him to conceal any evidence. He telephoned Dr. Cass the following day to discuss the matter with him and at that time learned that Dr. Cass had called a jury for April 5 to view the scene. He then advised Dr. Cass that he could carry on.

Dr. Shulman also admitted that the statement made by him was wrong. His evidence is as follows:

Q. "At this point (before hearing from Dr. Cotnam) the Fire Marshal had been despatched to examine the building and the inquest had been set for Wednesday night."

A. That was my impression. I have since learned that was wrong. [page 382 lines 12 to 18].

Dr. Shulman's statement that

"Dr. Cass then received a phone call from Dr. Cotnam's assistant instructing him not to hold the inquest. The implications are obvious."

carries an entirely different implication than would have been conveyed had he stated the true facts, namely: that Dr. Cotnam, the supervising coroner, had

attended at the scene, had decided that a jury should view the scene before evidence might be removed, had attempted to impanel a jury but had been prevented from doing so because of Dr. Shulman's wrongful intervention, that Dr. Cotnam wished to expedite the inquest, not cancel it, and that as a result of Dr. Cotnam's intervention, the jury did visit the scene before debris was removed. There is no disputing the fact that Dr. Shulman's inaccurate statement gave a false impression. Had he stated the facts accurately, no such implication could have arisen.

Dr. Shulman seemed to think that the issue was whether the Workmen's Compensation Hospital and Rehabilitation Centre was improperly built [page 385 lines 9 to 12]:

> Q. Oh, Dr. Shulman, the sinister implication that you are making in this allegation—
>
> A. The sinister implication is that this hospital was improperly built.

That was not the issue in this hearing, although it may have been the concern in the coroner's inquest. My concern was whether there was any evidence to substantiate Dr. Shulman's implication and allegations that Dr. Cotnam was trying to cover up or hold a mock inquest.

At the hearing Dr. Shulman suggested that Dr. Cotnam's conduct in attempting to take over the control of the inquest in this matter was improper, and gave three reasons why he believed this to be so. The reasons were:

1. That Dr. Cotnam had no authority under the Coroners Act;
2. That there was an agreement between Dr. Shulman and the Attorney General that Dr. Cotnam would not contact individual coroners in Metropolitan Toronto;
3. That Dr. Cotnam should have contacted either Dr. Shulman or Dr. Cass before attempting to take over.

Dealing with the first objection, the Coroners Act is quite clear that Dr. Cotnam did have authority, and reads:

> "2 (1) The Lieutenant Governor in Council may appoint a coroner for Ontario, to be known as supervising coroner, *who shall act in a supervisory and advisory capacity to coroners* and who shall have such other powers and perform such other duties as the regulations prescribe.
>
> 10 (3) After the issue of the warrant, no other coroner shall issue a warrant or interfere in the case, except the supervising coroner or except under the instructions of the Attorney General or the Crown Attorney."

Although the second reason given by Dr. Shulman is that there was an agreement between himself and the Attorney General, the evidence does not bear out his contention. Dr. Shulman's letter of April 3, 1967, to the Attorney General refers to an agreement. The letter reads as follows:

> "You will recall that in April of 1965, at the time of our most unfortunate public fracas, an agreement was made to prevent any future recurrence.

At that time I undertook to make no public comments respecting this occurring outside of Metropolitan Toronto, that I would release no critical comment of this department or its officials in that I would communicate with the department through the Supervising Coroner. Up until this moment I have taken care to comply with my portion of the agreement although there have been certain occasions particularly involving cases in other jurisdictions which in my opinion required comment.

In return I requested that Dr. Cotnam not interfere in the work of the Metro Coroner's Office nor call individual Metro coroners re their cases.

Last week a fire occurred at the Workmen's Compensation Hospital, in which preliminary inquiries indicate that there may have been negligence on the part of provincial authorities. One of our more able coroners, Dr. E. Cass, was assigned to investigate the fire and to hold an inquest. This has been set for April 5th, 1967. Today Dr. Cass was called by Mr. Jack Hills instructing him not to hold the inquest and saying that Dr. Cotnam would hold one in his place.

Inasmuch as this is in direct contradiction to our agreement and in addition carries the unpleasant implication that the government does not wish all the facts brought out, I have issued instructions to Dr. Cass to continue with the inquest and have so instructed the police; barring a direct order from you to the contrary.

If I receive such an order I shall understand that our agreement of April 1965 is no longer in effect.

Yours sincerely,

Dr. Shulman" [Pages 398 and 399]

In referring to the so-called agreement in his letter, Dr. Shulman says: "At that time I *undertook*", and in the next paragraph says: "In return I *requested*". The letter does not say: "you agreed, or you undertook". There is considerable difference between a request and an agreement. Had Dr. Shulman said: "At that time I undertook", and subsequently said: "In return you undertook", it might have substantiated what he said. On the contrary, Dr. Shulman's letter corroborates the evidence of Mr. Common, the Deputy Attorney General, who states that there was a request by Dr. Shulman that Dr. Cotnam not interfere in the work of the Metro Coroner's office, but there was no agreement that would in any way restrict the powers of the supervising coroner under the Coroners Act.

An examination of the earlier correspondence bears out Mr. Common. On April 5, 1965, Dr. Shulman wrote a letter to the Attorney General in which he said in part:

"I would respectfully like to make the following *suggestions* . . ."

And further in the letter he said:

"I must point out that co-operation should come from both sides and I would make two *requests* . . ."

The reply of the Attorney General, dated April 7, 1965, clearly sets out the Attorney General's position. It says in part:

"You have undertaken that . . ." and, "Now, I have noted your requests . . ." [page 411 line 28 and page 412 line 13]

Dr. Shulman took the position that since Dr. Cotnam hadn't taken over any inquests in Metro for two years, he was entitled to assume there was an implied agreement. He also stated that he had another letter "confirming an agreement" [page 413 line 26]. The letter was from Mr. E. Pepper, solicitor for Dr. Shulman, to Mr. Common, dated February 28, 1964. The relevant paragraph reads:

> "I have also explained to him that it is mutually acceptable to everyone that in the future both Dr. Shulman and the supervising coroner will follow proper channels in all matters so that if the supervising coroner is concerned about any matter arising in the County of York he will contact Dr. Shulman rather than individual assistant coroners and Dr. Shulman will follow the same procedure." [Ex. 21]

This letter does not confirm an agreement. It confirms that the Attorney General has instructed both Dr. Cotnam and Dr. Shulman to deal with each other through proper channels. The paragraph makes it quite clear that Dr. Shulman knew that Dr. Cotnam could exercise supervising control over the coroners in Metro Toronto. Since both parties were being instructed to do only that which they ought to do anyway, it could hardly be called an agreement.

When Dr. Cotnam was asked if he was aware of any agreement that any matter in York County would be referred to Dr. Shulman, he stated that not only had he never been told of any such agreement, but that on the contrary the Attorney General had instructed Dr. Shulman in his presence that he was to take instructions from the Supervising Coroner. The Coroners Act placed on Dr. Cotnam the responsibility for supervising coroners throughout all Ontario and any such agreement would be contrary to the statute.

Even if Dr. Shulman felt that Dr. Cotnam had no right to interfere in Metro Toronto, an intervention by Dr. Cotnam could hardly justify an allegation that the Government was attempting to whitewash and that Dr. Cotnam would conduct a mock inquest. These are allegations of criminal misconduct.

Mr. Hills, Dr. Cotnam's executive assistant, did call Dr. Cass, so that disposes of the third reason. It might have been more courteous had Dr. Cotnam followed the proper channels and contacted Dr. Shulman, but a lack of courtesy is hardly improper conduct.

The Attorney General replied on April 7, 1967, to Dr. Shulman's letter of April 3, 1967, as follows:

> "Dear Dr. Shulman:
>
> I received your letter of April 3, 1967.
>
> Your defiance of the Supervising Coroner for this Province is not only completely unwarranted, but a repudiation of The Coroners Act and my office. Your innuendo that this Government does not wish to have the facts brought out impugns not only the integrity of my officials, but also the Government, and constitutes an attitude that is quite inconsistent with the responsible and judicial character of the office of Chief Coroner.
>
> Your appointment as Chief Coroner for Metropolitan Toronto and as a Coroner for the County of York has therefore been terminated as of this date.

In view of the statements which you have made respecting the inquest into the death of Francesco Gualtieri, I have given instructions that you are to be subpoenaed before the inquest in order that you may disclose any facts or information that you deem relevant to the inquiry." [Page 403 line 30 to page 404 line 23]

The allegations made by Dr. Shulman to the press and to the television gave the impression that the Workmen's Compensation Board is a branch of Government. This is not so. The Workmen's Compensation Board, although a Crown agency created by statute, operates independently of the Government in compensating victims of industrial accidents from a fund created by contributions from industry. Whether this confusion was deliberate or unintentional, I do not know. Since the hospital was operated by the Workmen's Compensation Board, any negligence in operation would be the responsibility of that Board. The members and officials of the Board would therefore seem to be the only persons who would have an interest in any act of covering up. If there was to be a cover-up or a whitewash, it could not be accomplished without the complicity and co-operation of the Board and its officials. If the Board and its officials were people of honesty and integrity, they would not stand by and allow a whitewash. Yet Dr. Shulman does not question their integrity. His evidence at page 417 reads as follows:

Q. Do you challenge the integrity or the honesty of any member of the Workmen's Compensation Board?

A. No sir.

Q. Or any official in the Board's employ?

A. No sir.

There was no evidence that the Government tried to interfere with the inquest into the death of Gualtieri, and positive evidence that it did not. Dr. Cass, whom Dr. Shulman agreed was a man of integrity, stated on oath that there had been no interference with his investigation and that he had received complete co-operation from everyone.

Q. Now, has there been any interference with your full investigation of all matters that are relevant in this inquest?

A. No, there has been no interference at all.

Q. Have you received the complete co-operation of everybody who are the persons that would be normally expected to co-operate?

A. Yes, I think so. [Page 312 lines 18 to 26]

It was submitted that Dr. Cotnam, by reason of his office as Supervising Coroner for Ontario, ought to have refrained from making any inquiry into the Workmen's Compensation Board Hospital fire, as to which the jury and the public were entitled to know all the relevant facts and circumstances. There was no reason why he should not. He was empowered to do so by statute. Furthermore, the jury heard all the relevant facts and circumstances.

There was also an admission by Dr. Shulman at the hearing which implies that had he known that Dr. Cotnam made the decision to interfere on his own,

he might have worded his statement differently [page 400 line 17 to page 401 line 8]. His evidence is as follows:

> You say in your letter:
>
> "Inasmuch as this is in direct contradiction to our agreement and in addition carries the unpleasant implication that the government does not wish all the facts brought out."
>
> This is the allegation you are making.
> That is, everybody in the government so far?
>
> A. Yes.
>
> Q. Now, you heard Dr. Cotnam and Mr. Hills swear that the decision of Dr. Cotnam to conduct this inquest was his own. Did you hear him say that?
>
> A. Yes, I did.
>
> Q. Are you suggesting he is lying?
>
> A. No, sir.
>
> Q. Well if he made the decision on his own how can the implication be that the government did not wish all the facts brought up?
>
> A. I did not hear Dr. Cotnam swear to the contrary before I sent that letter, sir.

In deciding whether anyone was attempting to cover up, perhaps a comparison should be made of the conduct of Dr. Cotnam and the conduct of Dr. Shulman in dealing with this particular inquest. On April 3 when he learned that the date set for the inquest was not until May 2, and that no jury had been impanelled to visit the scene, Dr. Cotnam attempted to have a jury impanelled at once but was frustrated by Dr. Shulman who denied him the use of the facilities and the staff in the coroner's office. Dr. Shulman's behaviour towards his superior in this instance was incomprehensible. Without checking to see what justification there might be for his suspicions, Dr. Shulman wrote a letter to Attorney General A. A. Wishart that there was going to be an attempt to cover up. How could Dr. Shulman possibly reach this conclusion when the only evidence he had at that moment was that Dr. Cotnam wanted to impanel a jury to go and see the building before the evidence was removed? If Dr. Cotnam was trying to cover up, he certainly chose an unusual way to do it, trying to take a jury to see the evidence. How could any rational person believe such an allegation based on this evidence?

In considering how much weight should be attached to the statements of Dr. Shulman, one has to consider his conduct, his knowledge or information at the time he made the statements, and the evidence of other persons. When he makes a statement impugning the integrity of others, does he do so carelessly, without regard to the facts? His evidence as to intimidation of witnesses may give some indication in this respect. The subject was first brought up by Dr. Shulman during the inquiry. At page 319 line 16 the evidence reads:

> DR. SHULMAN: I have one further question.
>
> Q. Dr. Cass, following the police interview are you aware that one witness is so frightened he will not attend the Workmen's Compensation Board inquest?
>
> DR. CASS: I am not aware of that, no.

Further, at page 407 line 24, Dr. Shulman, when asked about his charges, said:

"Yes, sir. All right, then, the only other thing I would like to bring, I would like to call Mr. John Barnes. He may be here."

Q. What is his evidence about?

A. His evidence is about *intimidation* of a witness.

Q. Will you give me his name and I will interview him and you can interview your witness and we will call him the next day.

A. Yes.

Q. You have nothing else you want to say about the Workmen's Compensation Hospital inquest?

A. There may be one other thing. I just had a tape-recording taken of an interview held by a police officer and I wish to confirm that—

Q. Is that relating to your allegations?

A. It was relating to *intimidation* of a witness? [The italics are mine]

The implication is that someone was intimidating witnesses. He does not say who. Could it be the hospital authorities who had been charged by him with negligence? No one else would have any interest in doing so.

When Mr. Barnes was called he did not say that anyone was intimidated. At page 635 line 11 Mr. Barnes said:

"I am not saying that these policemen in any way intimidated the man. The only thing is they were frightened and I don't believe two immigrants should be frightened because they are visited by two policemen."

Q. You say now that they were not intimidated?

A. I never said they were. I said they were frightened.

MR. O'BRIEN: We brought you here because we were told you said they were intimidated.

MR. DUBIN: That is right. That is what Dr. Shulman said.

It seems clear from the evidence of this witness that he never said any witnesses were intimidated. He merely said that a witness was frightened when he received a subpoena. There is considerable difference between a witness being frightened and a witness being intimidated. The fact that a witness may be frightened when he receives a subpoena, especially when that witness is an immigrant, casts no reflection on anyone else. To suggest that a witness was intimidated is entirely different. Intimidation implies improper conduct on someone's part and leaves the implication that someone was trying to suppress evidence.

The two witnesses referred to by Mr. Barnes were Turman Romano and Samuel Umbriaco. When they were subpoenaed, the allegation of intimidation was shown to be groundless. Mr. Turman Romano was frightened because he had been served a subpoena at his place of employment, but his fears were only related to his employer. His evidence on this point is as follows [page 792 at line 16]:

Q. When the police came to your place of business did they say anything to you or just give you the subpoena?

A. They just gave me subpoena.

Q. There was no conversation?

A. I haven't conversation myself because, you know, I was frightened myself.

Q. Were you frightened by anything they said or just because they were there.

A. Frightened for the people where I work. The supervisor where I am working gave me call on the phone and he said, 'Two chaps here want to see you.' so I was started thinking who the two chaps are.

Q. Did they say anything to you?

A. No, really they didn't say anything to me.

Mr. Romano was seemingly concerned about what his employers might think. There was nothing in his evidence to suggest fear of the police.

Mr. Samuel Umbriaco gave evidence as to what took place when he was served with a subpoena to attend the inquest His evidence was as follows [page 796 line 28]:

Q. Did the police say anything to you?
Did they frighten or intimidate you when they gave you the summons?

A. No.

Q. Did you tell anybody that you had been frightened or intimidated?

A. No. I told the police that I did not want to be involved in this because what I knew—I didn't think was—

Q. Of very much help?

A. Of very much help.

Dr. Shulman could have checked into this matter himself before he made his allegation of intimidation which cast reflection upon the police, the officials of the Workmen's Compensation Board, and on the Government. Not only did he not attempt to find out the truth of the information he received, but he exaggerated it into something that was sinister and illegal without regard to the harm that his exaggeration could cause.

As it turned out, the facts on which Dr. Shulman based his allegations against Dr. Cotnam were wrong. At the time Dr. Cotnam intervened, he did so legally and properly.

Although Dr. Shulman at the hearing took the position that his remarks about the Government in his letter of April 3 to the Attorney General were not an allegation but a suggestion, after examining the facts it becomes clear that a reasonable person would not even have made such a suggestion. Dr. Shulman had no evidence of any suppression of evidence or cover-up in the Workmen's Compensation Hospital inquest.

PISECNY INQUEST

Dr. Shulman's allegations of political interference and of unlawful and improper suppression of evidence in this case were specifically directed against Mr. Common and Dr. Cotnam.

Louis Pisecny died of drowning in Lake Ontario after falling out of a boat on April 7, 1963. The inquest commenced on May 9 and Dr. Shulman presided. He had read that the Federal Government was considering amendments to the regulations governing small boats. Mr. Appleton, an employee of the Federal Department of Transport, was subpoenaed as a witness but refused to give his opinion regarding the regulations of his department. Dr. Shulman then adjourned the inquest so that another witness from the Department of Transport might attend.

Dr. Cotnam testified that he first heard of this matter from Mr. Common, who informed him about a telephone call he had received regarding a witness. He then wrote the following letter dated May 16, 1963, to Dr. Shulman:

> "I have had an interview with Mr. W. B. Common, the Deputy Attorney-General, and he informs me that there has been considerable discussion from various government departments in Ottawa concerning the conduct of the above inquest. [Page 531 lines 17-23]
>
> Inasmuch as I am not thoroughly acquainted with all the circumstances pertaining to this inquest, except through press reports, I would appreciate it if you would forward to me, at your earliest convenience, a complete report regarding this inquest so I may be in a better position for future discussion. Also, after I have thoroughly digested the contents of your report, I will call you for an appointment at my office to discuss the entire matter." [Page 531 lines 2 to 13]

Dr. Shulman replied on May 18 as follows:

> "As you have requested I will relate the information regarding this inquest.
>
> The death, that of a 30-year-old man, was the first drowning in Metro this year and occurred as the result of falling out of a boat which did not carry life-jackets.
>
> Under these circumstances I felt it would be wise to bring to the attention of the public the regulations concerning life-jackets. Inasmuch as there had been a report in the press that the Department of Transport was considering removing the regulations requiring the carrying of life-jackets in small boats I requested the detective in charge to subpoena a member of that Department.
>
> At the inquest I asked the representative of the Toronto Harbour Police a series of questions relating to life-jacket regulations and to what he believed would be safe practice. He very strongly recommended that life-jackets be

carried in all small boats. I then attempted to ask the same series of questions of Mr. Appleton the representative of the Department of Transport. He refused to give any opinions on these subjects, stating that all regulations come from the Governor-General, not from his Department, and that it was his job to enforce regulations not discuss them.

Under these circumstances and knowing that other members of his Department had felt free to discuss these regulations at previous inquests, I adjourned the inquest so that the Department of Transport could send down another representative who would be capable of assisting us.

After the inquest I spoke to Mr. Weaver of the Department of Transport and explained to him that it was not my desire to embarrass his Department nor to quarrel with it; that I had taken this inquest in the hope of preventing drownings this summer and that I hoped I would have the Department's co-operation toward that end.

I trust this is the information you require. If I can be of any further assistance to you please contact me. It is unfortunate that the Department of Transport has continued to hold the view that their infallibility must never be questioned even if improvements in their regulations would save many lives." [Page 422 line 9 to page 424 line 25]

Dr. Cotnam forwarded this letter to Mr. Common for his opinion and advice.

Mr. Common testified that he received a call from the Assistant Deputy Minister of Justice in Ottawa who had informed him that a subpoena had been issued to an official of the Department of Transport to testify as to Dominion Government policy with regard to small boat regulations passed under the Canada Shipping Act, and he took the position that a civil servant is not required to testify in regard to the policy of the government of which he is a public servant. Such an official could produce the regulations and testify as to their authenticity, but should not be asked what the future policy of the government might be. The question was not whether a civil servant should give evidence, but whether a civil servant was competent to give opinion evidence as to the propriety of a government regulation. Mr. Common stated that it was his own opinion that evidence of a civil servant giving an opinion on a legislative matter was not admissible and that it was improper for a coroner to request a witness from the Department of Transport to express his opinion as to a Federal regulation dealing with his department. In addition, he understood that the deceased was operating a power boat, whereas the regulations that the Federal Department of Transport were considering revoking dealt with unpowered boats, so the evidence was irrelevant in any event.

After discussing the matter with Dr. Cotnam, Mr. Common, on May 24, 1963, then sent the following letter to Mr. Henry Bull, Crown Attorney of York County:

Dear Mr. Bull,

re—Louis Pisecny—Inquest

The attached letter from the Chief Coroner of Metro was sent to me from Doctor H. B. Cotnam. Its contents confirm the complete irrelevancy

of the evidence Doctor Shulman wishes to have. This is not a case for an expert witness; moreover, the opinion of Civil Servants in relation to legislative policy of their government should not, under any circumstances, be entertained or even requested.

I am confident that you will make it perfectly clear to Doctor Shulman that under no circumstances must he explore this aspect of the matter.

It seems high time that Doctor Shulman should understand the basic purpose of a coroner's inquest.

I would appreciate your communicating with Don Christie of the Department of Justice. [Ex. 20]

Mr. Common testified that in giving this opinion, he was acting as Deputy Attorney General of the Province and received no instructions from the Attorney General or any other member of the government. He stated that so far as he was concerned he was giving a legal opinion as to the admissibility of evidence, that he was not suppressing evidence, that he received no directions or pressures, and did not know the deceased or his relatives or any of the persons involved in the inquest. He stated that the allegations of Dr. Shulman against him and his officials were completely without foundation.

Mr. Bull testified that when an inquest was ordered into this matter he assigned Mr. LeSage, a solicitor in his office, to act as counsel. He subsequently learned from Mr. LeSage that all the evidence that he considered to be relevant had been given, but there was some question about calling a witness from the Department of Transport to give opinion evidence as to proposed changes in the government regulations concerning life-jackets. Mr. Bull then received a telephone call from Mr. Common, followed by the letter which has already been referred to. He was advised by Mr. Christie of the Department of Justice that if the witness was compelled to attend, counsel would attend with him and would object to the evidence on the ground that it was not legally admissible. Since Mr. Bull agreed with Mr. Common's opinion as to the admissibility of the evidence, and with the position taken by Mr. Christie, he wrote the following letter to Dr. Shulman on May 27, 1963:

Re Inquest
Louis Pisecny, deceased

Dear Dr. Shulman:

I have been informed that the inquest conducted into the death of the above-named deceased has been adjourned in order to subpoena a witness from the Department of Transport to express his opinion as to the law, either statutory or regulatory, regarding small boats and life-jackets. I have been instructed by Mr. W. B. Common, Q.C., Deputy Attorney General, to say that this evidence is not relevant to the purpose of the inquest, which is to determine how, when and where the deceased came to his death, and is therefore not competent evidence. I have been informed by Mr. LeSage, Assistant Crown Attorney, who was present at the inquest on behalf of the Crown that all the evidence relevant to the cause of death has now been given.

Under these circumstances there seems to be no purpose to be served in bringing the witness from Ottawa, as he would have no relevant evidence to give. I have so informed Mr. D. H. Christie of the Department of Justice.

However, I have said that, unless the subpoena is withdrawn, it will be necessary for him to attend at the resumed hearing although objection will be taken to any opinion evidence that might be called for.

May I have your advice that the subpoena has been withdrawn and the witness need not attend for any purpose." [Page 521 line 12 to page 522 line 23]

This is the documentary evidence on which Dr. Shulman bases his allegation of political interference.

Mr. Bull testified that in coming to his opinion as to the competency of the witness and the relevancy of the evidence, he was not motivated by political consideration or an attempt improperly to suppress evidence. He considered that it was his duty to see that a Court of Record was conducted according to the established rules of evidence and procedure. He received a reply from Dr. Shulman dated May 28, 1963, which read:

"Dear Mr. Bull:

Re: *Pisecny Inquest*

I have read with interest your letter of May 27th, 1963.

If I were to accept your view as to the purpose of an inquest I would withdraw this subpoena. However, to quote the Attorney General's 'Advice to Coroners' in 1960, the purpose of an inquest is to provide a 'Verdict that will provide a guide to prevent the repetition of the same type of death in the future'.

As Pisecny's death occurred as a result of a breach of regulations which are unclear, an expert's opinion is necessary.

Despite this situation, which I believe necessitates a proper completion of this inquest, I have presented the facts to Mr. Cass, and I will abide by his decision.

Yours truly,
Morton Shulman."

[Page 523 line 8 to page 524 line 1]

Dr. Shulman obviously directed his mind to the purpose of the inquest and not to the question of admissibility.

After talking to Mr. Common, Dr. Cotnam telephoned Dr. Shulman and told him Mr. Common's opinion, that the evidence was not admissible and the subpoena should be cancelled. He suggested that he secure an expert witness who did not have the disqualification of being a civil servant giving opinion evidence on his own legislation. Dr. Shulman did not agree with him.

Dr. Cotnam stated that he realized that Dr. Shulman was trying to give instructions to the jury as to recommendations, and he agreed with the purpose but he did not agree with his manner of doing it.

Dr. Shulman then wrote to the Attorney General. His letter dated May 27, 1963, was as follows:

"Dear Mr. Cass:

An awkward situation has developed which I felt I should draw to your attention immediately. I am enclosing earlier correspondence which will explain the situation.

The inquest has been adjourned to Wednesday, May 29th, in order to allow testimony from an official of the Department of Transport. Today I was instructed by Dr. Cotnam, the Supervising Coroner, that I must cancel the subpoena for this individual and close the inquest without his testimony.

Inasmuch as there has been wide public interest in this inquest not only by the Press (in which editorials have already been written) but also by the CBC and the independent stations (one of whom have completely taped the inquest to this point) I fear that if I follow these instructions there will be an outcry which will reflect badly on our Department.

I would appreciate receiving your instructions." [Page 540 line 22 to page 542 line 3]

Dr. Shulman's letter to the Attorney General makes it clear that he had taken a position in a matter that was receiving extensive publicity and that he was more concerned with publicity than legality. He obviously did not think his comment about the Department of Transport holding the view that "their infallibility must never be questioned" might also apply to him. Most people would consider it no disgrace for a person untrained in law to admit he was in error in calling a witness who was not legally competent. Neither would they think it unreasonable for a coroner to accept advice as to admissibility of evidence from the Crown Attorney and Deputy Attorney General, especially when told that there was a proper way to admit such evidence by calling another witness.

Attorney General Cass replied to Dr. Shulman's letter on May 31. His letter reads:

"Your letter of May 27th last is acknowledged, and, of course, did not reach me in time for any definite action to be taken by me with respect to your request for direction.

However, during my absence from the office, the Deputy Minister I believe dealt with the matter and I must advise you that I heartily concur in his views and direction.

It is most unfortunate that matters such as this should be dealt with by you in your official capacity without the full authority and cooperation of the Supervising Coroner and the Deputy Attorney General.

I trust that such a situation will not arise again in the future." [Page 546 line 21 to page 547 line 11]

Dr. Shulman did not withdraw the subpoena. The inquest reconvened on the evening of May 29, 1963. The witness and his counsel attended from Ottawa, the questions were asked, the objection was taken and the witness did not answer.

At no time did Dr. Shulman talk to Mr. Common throughout this whole affair. His allegations against Mr. Common were therefore based on what Mr.

Bull had put in his letter and on what Dr. Cotnam had told him. He knew Mr. Common was giving a legal opinion.

According to Mr. Common, he saw Dr. Shulman shortly after this on the television and Dr. Shulman said at that time:

> "Officials of the Attorney General's Department were guilty of political interference, protecting quack doctors and protecting incompetent federal officials."

Dr. Shulman agreed that he used these words. [Page 458 lines 18-22]

A newspaper report of January 28, 1964, read in part:

> "Metro's Chief Coroner Dr. Shulman last night demanded a public inquiry into what he called political interference with the Ontario Coroners' System.
>
> Dr. Shulman revealed letters which he claims prove that Mr. Common and Supervising Coroner Dr. H. B. Cotnam interfered with an inquest last May. Dr. Shulman said he had received the letter from Toronto Crown Attorney Henry Bull and Attorney General Cass criticizing his conduct of the Pisecny inquest. He said the letter from Mr. Bull instructing him to cancel the Ottawa subpoena was written at Mr. Common's request. Mr. Common called Shulman a liar for charging political interference but later said he did not like to use the word in reference to a professional man. In a statement the Chief Coroner said the life-jacket incident was the most flagrant in a series of cases in which Mr. Common and Dr. Cotnam have tried to hide the facts. 'Their attitude has been that incompetent officials and quacks in medicine deserve protection before the public.' Dr. Shulman said neither Common nor Dr. Cotnam are fit to hold office. 'I do not believe that the government will allow men of such ethics to control the Coroners' system in Ontario. I call for a public inquiry before which I shall present documentary evidence'." [Page 548—page 551]

Mr. Common also gave evidence regarding a meeting held by the Attorney General some time in February of 1964 so that he could hear Dr. Shulman's complaints and investigate them. Present at the meeting were the Attorney General, Dr. Shulman, the Deputy Attorney General and two or three other officials of the Attorney General's Department. On that occasion Dr. Shulman discussed several matters, one of which was the Pisecny case. Mr. Common noted each of Dr. Shulman's complaints and reported to the Attorney General on each. In addition the Attorney General requested Mr. Dick, who was independent of the Coroner's work in the Department, also to investigate and make a report to him. Subsequently Mr. Common saw Mr. Pepper, a solicitor who acted for Dr. Shulman, and discussed the various matters raised by Dr. Shulman. He explained the position of the Attorney General's Department in relation to each. He later received a letter dated February 28, 1964, from Mr. Pepper:

> "Pursuant to our discussion yesterday, I explained fully the position of the Attorney General's Department to Dr. Shulman and he is quite satisfied that a meeting be held at any time at your convenience. He was fully satisfied with the explanation furnished to him and he is quite content to allow the matter to rest with or without a meeting." [Page 438]

Mr. Common stated that he also discussed with Mr. Pepper the question of complaints being funnelled along regular administrative lines before being released to the press. In other words, any complaints from Dr. Shulman should be made to the office of the Supervising Coroner, and any complaints affecting the coroners in Metropolitan Toronto should be drawn to the attention of Dr. Shulman in the first instance. The letter continued:

> "I have also explained to him that it is mutually acceptable to everyone that in the future both Dr. Shulman and the Supervising Coroner will follow proper channels in all matters so that if the Supervising Coroner is concerned about any matter arising in the County of York, he will contact Dr. Shulman rather than individual assistant coroners and Dr. Shulman will follow the same procedure." [Page 442]

Mr. Common testified that this did not in any way interfere with the Supervising Coroner's statutory responsibility in supervising matters in the County of York. The letter continued:

> "I also understand that it is mutually acceptable that whether or not the meeting is held the final release to the press will be in the form such as the following: 'It is agreed by everyone that the integrity of the Coroner's Office will be maintained and that all issues herein have been fully resolved.' Dr. Shulman has also asked me to point out to you that since the reorganization his position has become much more time-consuming than ever in the past." [Page 442-3]

Following receipt of this letter Mr. Common sent a memorandum to Mr. Dick dated March 4, 1964, which reads:

> "I am quite intrigued by the suggestion of Dr. Shulman that the integrity of the Chief Coroner's Office must be maintained.
>
> "As far as this Department is concerned, the integrity of the Chief Coroner's Office was never in jeopardy, but, on the contrary, Dr. Shulman's charges certainly question the integrity of the Attorney-General and his officials. I feel that nothing short of a statement from him that the advice given to him in respect of the various matters raised by him had been misinterpreted by Dr. Shulman."
>
> "A general statement including this aspect will of necessity have to follow a second meeting when the position of the officials of this Department is made clear." [Pages 444-5]

Because of Mr. Pepper's letter, no second meeting was held. Dr. Shulman denied that Mr. Pepper was retained by him as his solicitor.

Mr. Elliott Pepper, Q.C., testified that he had at times acted for Dr. Shulman prior to February of 1964 and at one time had been an officer in the Department of the Attorney General. He had held the office of Queen's Proctor. He could not say whether he was acting under retainer for Dr. Shulman but in any event he met with Mr. Common and discussed Dr. Shulman's complaints with him. During the meeting with Mr. Common, Mr. Pepper scribbled some notes which he kept in his file. He testified that he wrote the letter of February 28 presumably

on Dr. Shulman's instructions and said it was unlikely that he would write such a letter without instructions, for he said in the letter:

> "Pursuant to our discussion yesterday I explained fully the position of the Attorney General's Department to Dr. Shulman. He is quite satisfied that a meeting be held at any time at your convenience."

Mr. Pepper testified that Dr. Shulman was fully satisfied with the explanation furnished. He stated that he would not have written the letter had this not been so.

Dr. Shulman denied that there was any discussion of individual cases with Mr. Pepper. He was then asked:

THE COMMISSIONER: You are suggesting that Mr. Pepper wrote that letter without authority?

THE WITNESS: Oh, no, he had my full authority, sir. He asked if he could write letters sending it out. He sent me a copy of it. It suited me fine. [Page 577 lines 13-18]

At the inquiry he was asked what the basis was for his allegation of political interference. He stated that the first letter he received from Dr. Cotnam referred to an interview with Mr. Common in which Mr. Common said that he had had considerable discussion with government departments in Ottawa. He then attended at Dr. Cotnam's office on May 27, 1963, and Dr. Cotnam instructed him to cancel the subpoena for the Department of Transport, stating that he was acting under the direction of Mr. Common, the Deputy Attorney General. When he asked why, Dr. Shulman stated that Dr. Cotnam replied that Mr. Christie, a friend of Mr. Common in the Justice Department, had phoned requesting that the subpoena be cancelled because it would embarrass the Deputy Minister of Transport if the witness gave evidence.

At the inquiry Dr. Shulman testified that he thought it was sinister that evidence should be suppressed because it would be embarrassing to the Deputy Minister of Transport. [Page 557 lines 19 to 22]. Dr. Shulman's use of words like "sinister" and "suppressed" implies that the actions of various people were improper, whereas what they were doing was legal and proper. His allegation of suppression seems inconsistent with what he said in his annual report for 1963, in which he referred to the Pisecny inquest and said:

> "Despite the vigorous pressures exerted by the Federal Department of Transport the life-jacket inquest heard all witnesses and brought in a proper verdict."

Dr. Shulman's 1966 annual report, which was released in 1967, said:

> "Very important is the fact that every death in the last four years has been investigated openly and completely with all the facts brought to the attention of the public in contrast to experience previously and elsewhere."

This would cover the Pisecny Inquest and would indicate there was no suppression. I do not know what caused Dr. Shulman to change his mind after he wrote this report, but the change makes one doubt his sincerity and his credibility.

Apparently the assistant counsel for the Justice Department saw nothing sinister in the use of the word "embarrassment" because according to the press report of the inquest he used that word in making his submission to the coroner. The report in the *Globe and Mail* of May 30, 1963, reads:

> "Pressure from the Crown Attorney and a counsel for the Federal Department of Transport stopped Chief Coroner Morton Shulman from asking a Civil Servant about his opinions on lifesaving regulations at an inquest last night.
>
> The inquest was into the April 7th drowning of Lou Pisecny, 30, of Montrose Avenue. He fell from a boat off Marie Curtis Park in Lake Ontario. He was not wearing a life-jacket and the only life-jacket aboard the boat was designed for a child's use.
>
> It was the second time that Dr. Shulman was unable to get an opinion from a Civil Servant. Last week Thomas Appleton, Small Boats Officer with the Marine Regulations Branch of the Department, said that as a Civil Servant he could not give his opinion on proposed legislation. Dr. Shulman adjourned the inquest until another witness could be found." [Page 564-5]
>
> The witness, Keith Angus, Superintendent of Nautical Safety for the Department, came from Ottawa with R. R. Macgillivray, Assistant Counsel for the Department—.
>
> 'I object to the witness being asked to express an opinion on what government policy should be or on what the law should be,' Mr. Macgillivray said.
>
> Mr. Macgillivray's objection came after Dr. Shulman asked Mr. Angus if the licensing system for boats in Toronto harbour should include a wider area.
>
> Mr. Macgillivray said the answer might be an embarrassment to Mr. Angus later and it could be an embarrassment to the Transport Minister.
>
> Crown Attorney Patrick LeSage said Dr. Shulman was stepping outside the scope of the inquiry. He said the inquiry was into how an individual died." [Page 566-7]

To most people the fact that the Crown Attorney, the Deputy Attorney General, the Attorney General and a solicitor from the Department of Justice expressed an opinion that certain evidence was inadmissible, would indicate that the opinion was entitled to some respect. Regardless of the competence or compellability of the particular witness, it would seem that the evidence was irrelevant in any event. There was nothing unlawful or improper in the solicitor for the witness making submissions as to competence, compellability and admissibility. It was not unlawful or improper interference for the Deputy Attorney General to give an opinion that a witness was incompetent, that certain evidence was inadmissible and that a subpoena should be withdrawn. It was not unlawful or improper interference for Dr. Cotnam to pass on this opinion and advice to Dr. Shulman. A legally competent witness did give opinion evidence on the same subject, so there was no unlawful or improper suppression of evidence in relation to this inquest.

Because of his ignorance of the law, Dr. Shulman tried to do something that he had no right to do. His legal advisers were not telling him he could not put in certain evidence; they were telling him that he could not put in the evidence

the way he wanted to. On the basis of these facts he irresponsibly suggested that the persons who disagreed with him were suppressing evidence, were guilty of political interference, and were completely indifferent to public safety and the public interest.

I find there was no unlawful or improper suppression of evidence or no unlawful or improper interference by any member of the government or senior official of the Department of the Attorney General in this matter, nor were they indifferent to the public safety and the public interest.

GEORGE INQUEST

Mrs. Elizabeth George died of cancer on August 11, 1963, shortly after admission to the Humber Memorial Hospital. Dr. Donald G. Bunt, a Coroner in Metropolitan Toronto, investigated the death and recommended that an inquest be held. Following this recommendation Dr. Bunt received a message from Dr. Shulman advising him that he had taken over the case.

Dr. Shulman commenced the inquest but before it was completed an application was made to the Supreme Court of Ontario by counsel for Dr. Y., the attending physician, for an Order quashing the inquest on the ground that Dr. Shulman had no jurisdiction, and such Order was made by Mr. Justice Morand on October 1, 1963.

Immediately after the Order was granted quashing the inquest, Dr. Cotnam, the Supervising Coroner for Ontario, heard that Dr. Shulman had set a time for a new inquest. On learning this Dr. Cotnam attended at the office of the Chief Coroner and a dispute arose between them. Because of the difference of opinion between his two superiors, Dr. Bunt sought advice from Mr. W. B. Common, Q.C., the Deputy Attorney General. Dr. Bunt decided that no inquest should be held.

This was one of the cases named by Dr. Shulman in which he had alleged that there had been an unlawful or improper suppression of an inquest. The persons against whom he made the allegation were Dr. Cotnam and Mr. Common. In giving evidence, Dr. Shulman stated that Elizabeth George died on August 12, 1963, from cancer, following long treatment by a Toronto physician "using a cancer serum proved useless years before". After stating that Dr. Bunt investigated the death and recommended that an inquest be held, Dr. Shulman said:

> "I took over this case following the practice of my predecessor and began the inquest." [Page 677 lines 20 and 21]

This statement would seem to be an attempt by Dr. Shulman to blame someone else rather than admit that he was wrong even on a trivial issue. Section 10(3) of The Coroners Act provides:

> "After the issue of the warrant no other coroner shall issue a warrant or interfere in the case except the Supervising Coroner or except under the instructions of the Attorney General or the Crown Attorney."

Dr. Shulman's predecessor is dead and cannot attest whether or not he followed this practice, but even if he did, that would not justify Dr. Shulman in doing so. Dr. Shulman's predecessor was both Supervising Coroner and Chief Coroner for Metropolitan Toronto. Under the Section, the Supervising Coroner has a right to interfere; a Chief Coroner has not.

Dr. Shulman stated that on October 1, 1963, while he and Dr. Bunt were in his office discussing the quashing of the George inquest, he set a time for a new

inquest and instructed Dr. Bunt to hold it. When Dr. Shulman first gave evidence on this point he said:

> "Dr. Cotnam instructed Dr. Bunt that no inquest was to be held." [Page 678 lines 3 and 4]

And on a later occasion he said:

> "Dr. Cotnam ordered Dr. Bunt not to hold the inquest." [Page 712 line 30 to page 713 line 5]

He further testified:

> "I attempted to hold an inquest in the case of a medical quack. They prevented the inquest from being heard. They prevented the quack from being exposed. And, as such, they acted improperly." [Page 689 line 30—page 690 line 4]

Since there was a conflict in the evidence as to whether Dr. Cotnam or Mr. Common instructed or ordered that an inquest not be held, or prevented the inquest from being held, or prevented a quack from being exposed, I refer to the evidence of the witnesses.

Dr. Cotnam in evidence stated that on October 1, 1963, while attending at the morgue on Lombard Street with his executive assistant, Mr. Hills, he had a discussion with Sergeant Cruickshank of the Metropolitan Toronto Police, who at that time was assigned to the Coroner's office. On learning from Sergeant Cruickshank that Dr. Shulman had rebooked the George inquest for the following Thursday, Dr. Cotnam attended at Dr. Shulman's office and asked him if he had rebooked the inquest. Dr. Shulman stated that he had not, that Dr. Bunt had done so. Dr. Bunt was then called by Dr. Cotnam and in front of Dr. Shulman asked whether he had set the date for the inquest. Dr. Bunt testified that he had not. The fact that Dr. Shulman was shown up in front of his own staff no doubt increased the animosity between Drs. Shulman and Cotnam.

A dispute followed as to who had authority to order this inquest to be held. Dr. Shulman states that he ordered Dr. Bunt to hold one but that Dr. Cotnam instructed Dr. Bunt not to. Dr. Cotnam states that he told Dr. Shulman that he had no authority to order an inquest, that the Court had just set aside the previous one because of his interference, and that he did not wish Dr. Shulman to interfere again. Dr. Cotnam stated that because of the evidence given on the prior inquest, no further inquest was necessary, but only Dr. Bunt could make that decision. He further testified that he told Dr. Shulman that the matter should be referred to the College of Physicians and Surgeons.

On cross-examination Dr. Shulman was asked the following [page 695 lines 1 to 7]:

> Q. Did not Dr. Cotnam on that occasion suggest to you that it was not necessary to reconvene an inquest because the matter was one for the College of Physicians and Surgeons?
>
> A. I am not sure what his—There were a number of arguments he presented. This probably was one of them. I think this would be reasonable.

Dr. Shulman admitted that he wished to continue with the inquest, not for the purpose of ascertaining the cause of death, but for the purpose of exposing Dr. Y. [Page 699 line 29 to page 700 line 4].

Dr. Bunt stated that when he arrived at Dr. Shulman's office, Dr. Shulman, Dr. Cotnam and Mr. Hills were present and a heated argument was going on as to whether anyone had the legal power to tell Dr. Bunt what to do about the inquest. At that time Dr. Shulman denied that he had set a time for the inquest. Dr. Cotnam then asked Dr. Bunt whether he had booked the inquest and he said he had not. Dr. Bunt stated that Dr. Cotnam advised him that an inquest was not necessary but that no one could order him to hold or not to hold one; the decision was his own. Dr. Bunt testified that since his two superiors were of different opinions as to what he should do, he determined to obtain advice from Mr. W. B. Common, Q.C., the Deputy Attorney General.

This would indicate that Dr. Bunt did not accept either advice or order, but intended to make up his own mind after learning the extent of his authority. He consulted with Mr. Common who advised him that legally another inquest could be held and the decision whether or not to hold one was entirely up to him. They then discussed the facts. Dr. Bunt stated that when he left Mr. Common he had still not made up his mind whether or not to hold an inquest. Before deciding he discussed the matter further with Dr. Shulman and then decided that no inquest should be held. Dr. Shulman agreed that what Dr. Bunt had told him was that Mr. Common gave him advice but did not direct what he should do. [Page 715 lines 12-14].

Mr. Common in giving his evidence stated that Dr. Bunt sought his legal opinion as to whether another inquest could be held, and concerning who had power to make the decision. He advised Dr. Bunt that an inquest could be held and that the decision was Dr. Bunt's alone. Mr. Common stated that he and Dr. Bunt then discussed whether or not an inquest should be held. He stated that Dr. Bunt advised him of the alleged unorthodox practices of Dr. Y. but stated that there was no connection between the treatment and the patient's death and that the sole purpose of the inquest would be to expose the unorthodox practices of Dr. Y. Mr. Common testified that he then advised Dr. Bunt that he did not think an inquest should be used for this purpose, that the proper procedure was to lay a complaint with the College of Physicians and Surgeons.

Following his meeting with Dr. Shulman, Dr. Bunt released a statement to the press. The report in the *Globe and Mail* read:

> "Dr. Bunt said yesterday, the decision not to re-open the inquest had been his own, adding it had been made in consultation with Dr. Shulman. 'We have decided that a complete investigation has been done. No further inquest will be held and we are forwarding our investigation findings to the appropriate authorities, that is the College of Physicians and Surgeons and the Department of the Attorney General.' " [Page 1718 line 6 to page 1719 line 10]

Dr. Bunt swore that this was a true statement and I believe him. Dr. Shulman testified that Dr. Bunt was an honourable man. [Page 706 line 29].

When Dr. Shulman was shown the press release and asked whether it was true, he was evasive and would not admit that the statement was true. [Page 717 line 9 to page 720 line 22]. When asked whether he had ever seen the statement before, he answered:

"I probably saw it but I don't recall it." [Page 720 lines 23-30]

He was then shown a document in his own handwriting in the exact words of the press release given by Dr. Bunt. Dr. Shulman then admitted that he prepared the statement with Dr. Bunt. [Page 722 lines 12 to 14]. Dr. Shulman was then asked [page 722 lines 15 to 18]:

Q. And would it not be true or did you make a false press release?

A. It is not a false statement, sir.

The evasion of Dr. Shulman was understandable. The press report corroborates the evidence of Dr. Cotnam and Mr. Common; it contradicts the evidence of Dr. Shulman.

In view of the press release prepared by Dr. Shulman, which makes it abundantly clear that the decision not to hold an inquest was Dr. Bunt's, I find that Dr. Shulman knew at that time that neither Dr. Cotnam nor Mr. Common had instructed or ordered Dr. Bunt not to hold an inquest. Not only therefore was there no evidence to support this serious allegation, but Dr. Shulman knew at the time he made it that it was not true. He nevertheless persisted in pressing the allegation before me.

Dr. Shulman at the hearing submitted that if the George inquest had been held and completed, Dr. Y. would have been exposed as a medical quack to the public and they would have been warned away from him. [Page 688 line 28 to page 689 line 2]. This may be so but it does not necessarily follow that because Dr. Cotnam and Mr. Common did not agree that an inquest should be held that they were unlawfully or improperly suppressing an inquest. It was their view that the matter should be brought to the attention of the Discipline Committee of the College of Physicians and Surgeons where a board of qualified doctors would decide questions of medical practice, but they did not agree that an inquest should be used for this purpose. I agree with their view.

Dr. Shulman stated that medical testimony at the inquest definitely established that Mrs. George might have recovered if she had received standard treatment. Dr. Henry Goldenberg was called by Dr. Shulman and supported this view. This is different from maintaining that Mrs. George died because of the medical treatment she received. On cross-examination Dr. Goldenberg admitted that at the inquest into the death of Mrs. George there was evidence given by a physician who had first seen her and diagnosed her condition as cancer. This physician recommended conventional treatment by surgery but she refused to follow his advice. The evidence was that if this woman had accepted the advice given to her initially she would have had a good chance of a cure. She chose not to accept conventional treatment, preferring to accept the treatment of Dr. Y.

Dr. Shulman then stated in evidence:

"Following Dr. Bunt's meeting with Mr. Common I determined to try to rid the city of this medical quack and a most incredible series of events followed." [Page 678 lines 15 to 18]

The evidence he then gave did not relate in any way to Dr. Cotnam or Mr. Common, but to the College of Physicians and Surgeons. Dr. Shulman laid a charge against Dr. Y. with the College and in due course the Discipline Committee of the College held an inquiry and Dr. Y. was found guilty of two charges of improper conduct. The council directed that Dr. Y. be erased from the register and placed on the temporary register with full practice privileges provided he did not employ serum in the treatment of any cancer patients. Dr. Shulman found this decision disturbing and mysterious and drew certain implications from this result.

The evidence reads [page 688 line 14]:

"THE WITNESS: The mystery of why the doctor did not lose his licence was solved on December 12th, 1964, when Dr. Y. issued a statement in which he said, and I quote:

'During the investigation by the Disciplinary Committee of the College they expressed themselves as being impressed by the calibre of the witnesses called in my defence.'

I request that the officials of the College be questioned as to who were the high-calibre witnesses who persuaded the College to allow this man to continue in practice; and specifically were they connected with the Progressive Conservative Government."

Although Dr. Shulman first states that the mystery of why the doctor did not lose his licence was solved, he indicates that he has no facts to support his conclusion by asking two questions. These questions imply that the Discipline Committee of the College of Physicians and Surgeons did not reach an honest decision but was wrongly influenced by some unknown persons connected with the government.

Dr. Shulman was unable to produce any evidence to support these innuendoes.

Dr. Shulman did not know who the witnesses were that were called, but said that no high-calibre member of the College of Physicians and Surgeons would appear for Dr. Y. [Page 703 line 28 to page 704 line 3]. It seems obvious that if he did not know who the witnesses were, he was in no position to say whether or not they were of high calibre. Dr. J. W. Kucherepa, the Assistant Registrar of the College of Physicians and Surgeons, was called in an attempt to find out whether there was any substance to Dr. Shulman's innuendo. He stated that four physicians were called during the hearing. Two of these were members of the College of Physicians and Surgeons of Ontario and two were from the United States. One of the witnesses from the College of Physicians and Surgeons was Dr. Gordon Murray, a graduate of the University of Toronto, a surgeon

certified by the Royal College of Physicians and Surgeons of Canada, a Fellow of the Royal College of Surgeons, a senior surgeon on the staff of the Toronto General Hospital and a member of the Faculty of Medicine of the University of Toronto. According to Dr. Kucherepa, Dr. Murray is considered to be one of the most eminent members of the medical profession. The other witness from the College of Physicians and Surgeons was Dr. Neil E. McKinnon, a certified specialist in Bacteriology and Public Health, who was associated with the University of Toronto School of Hygiene and the Faculty of Medicine of the University of Toronto. Dr. Kucherepa said that Dr. McKinnon was outstanding in his particular field. Neither Dr. Kucherepa nor Dr. J. C. C. Dawson, the Registrar of the College of Physicians and Surgeons, who also gave evidence, knew of any connection that Dr. Murray or Dr. McKinnon might have with the Government of Ontario.

Dr. Shulman suggested that the Discipline Committee of the College of Physicians and Surgeons was afraid to discipline a cancer quack for fear of losing its licensing powers. [Page 701 lines 7 to 8]. When asked whether he had any evidence to support this allegation, he replied that his remark was a question, not an allegation. When asked if he knew anything about the College being afraid of losing its licensing powers, Dr. Dawson stated that he had never heard this opinion voiced either by government circles or by members of the College. He stated that the College of Physicians and Surgeons is a statutory, self-governing body, given the sole right to discipline its own members, and in the case of Dr. Y., when the matter came up before the College, there was no interference with the decision of the College by any senior officer of the Department of the Attorney General or of the Government.

Dr. Shulman stated in evidence that the members of the council of the College of Physicians and Surgeons were not active practitioners but retired. [Page 726 lines 13 and 14]. Dr. Dawson gave the names of the five members of council who served on the Discipline Committee on the Dr. Y. case and stated that all were in active practice at the time the committee sat. [Page 837 lines 5 to 12]. Apparently Dr. Shulman made this statement without knowing the true facts.

During the inquiry into this particular matter, it was obvious that Dr. Shulman made many statements that simply were not supported by the facts. He drew inferences that no reasonable person could draw. His opinions were surmise based on suspicion.

To suggest, even by way of innuendo, that the Government would interfere with the proceedings of the Discipline Committee of the College of Physicians and Surgeons, to protect someone that the College thought ought to be disciplined, is not only negated by the evidence, but is completely irresponsible.

POWER INVESTIGATION

Dr. Shulman testified that this matter first came to his attention on September 31, 1963, when he received a telephone call from Mr. J. C. Dawson, Registrar of the College of Physicians and Surgeons, regarding Miss Margaret Power, who died of cancer on May 8, 1962. According to Dr. Shulman, Dr. Dawson asked him if he would be willing to hold an inquest to expose Dr. X. and warn the public against him. He then received a letter from Dr. Dawson enclosing an *ante-mortem* statement on Margaret Power. This indicated that she was examined in hospital in March of 1960, at which time cancer was suspected, and she was advised to have surgery. She refused. From June, 1960, to August, 1961, she was treated by Dr. X. with health foods and serum injections.

On September 14, 1961, she was admitted to the Princess Margaret Hospital on the advice of another doctor and found to be suffering from an advanced cancer of the breast. She was discharged from hospital on April 26, 1962, and died at her home on May 8, 1962. Dr. Shulman testified that because Miss Power was buried outside Metropolitan Toronto, the only way he could have an inquest would be to secure an order from the Attorney General's Department authorizing him to hold one.

He called Dr. Cotnam, who suggested that he call Mr. Common. He then got in touch with Mr. Common regarding the matter. Dr. Shulman testified that Mr. Common gave him three reasons for not giving his permission: first, the problem was one for the College of Physicians and Surgeons; second, it was over a year since the death had occurred; and third, that a lot of doctors were upset about the George inquest and he did not feel the profession should be further upset at the present time. [Page 2807 lines 6-20]

Dr. Shulman testified that Mr. Common told him to leave the papers with him and he would give the matter further consideration and let him know. He stated that a few days later Mr. Common telephoned him and said he would not give him permission and that he was returning the papers by registered mail. [Page 2807 lines 25-28]

Dr. Shulman then wrote a letter to the College of Physicians and Surgeons requesting that charges be laid against Dr. X. In due course the council found Dr. X. guilty of professional misconduct and directed that his name be erased from the register of the College of Physicians and Surgeons of Ontario.

Dr. Shulman's allegation of unlawful and improper suppression of an inquest, specifically made against Mr. Common, is based on his statement that Mr. Common refused him permission to hold an inquest.

Dr. Shulman was questioned by commission counsel regarding his meeting with Mr. Common. He was referred to a letter written by himself to Dr. Cotnam on September 25, 1963, which related in part to this matter, as follows:

> "2. *Exhumation Case*
>
> The College of Physicians and Surgeons requested that I hold an inquest into the death of Miss Margaret Power which occurred May 18th, 1962. I made a complete investigation of her death and then saw Mr. Common for advice re the necessary exhumation. He advised me against holding an inquest because of the long period of time since her death and other factors, and I have followed his advice." [Page 2817 line 28—page 2818 line 26]

It is significant that Dr. Shulman at that time used the word "advice". He did not say that he requested and was refused permission. Dr. Shulman was then referred to an article in the *Globe and Mail* dated September 23, 1963, which reads:

> "Dr. Shulman told the Globe and Mail last night he considered holding an inquest into the woman's death and *decided* not to because of the length of time since the woman's death." [my italics]

Dr. Shulman was then asked whether he told the *Globe and Mail* that he decided not to hold an inquest because of the length of time since the woman's death. His answer was, "I told him the whole story, but did not mention Mr. Common." [Page 2820 lines 5 and 6]

Counsel referred to the following direct quotation by Dr. Shulman:

> "I made a complete investigation of her death and then saw Mr. Common for advice re the necessary exhumation."
>
> "He advised me against holding an inquest because of the length of time since her death and other factors, and I have followed his advice."

Dr. Shulman agreed that this was his language. [Page 2823 lines 17 and 18]. It indicates that he sought advice and followed the advice, not that he requested permission and was refused.

Dr. Shulman was then referred to the Toronto *Telegram* of September 24th, which reported as follows:

> "Dr. Shulman said yesterday he had considered holding an inquest into Miss Power's death but *decided* against it because she died so long ago." [my italics] [Page 2824 lines 6-9)]

Both reports indicate that Dr. Shulman decided, not that he was refused permission. If permission had been refused, no decision would have been necessary. Dr. Shulman denied making this latter statement. He testified that he told both reporters the full story and asked them to summarize it without mentioning Mr. Common. If that were so then both reporters were guilty of distorting the facts. I find it difficult to believe that two reporters on different papers were told that the Deputy Attorney General refused to grant permission to hold an inquest, that they withheld this information, then published stories containing quotations from Dr. Shulman which indicated that the decision was his.

Mr. Common stated that at no time did he direct Dr. Shulman not to hold an inquest, but advised him to consider—in view of all the circumstances—whether one should be commenced. He testified that he advised Dr. Shulman that the request of the College of Physicians and Surgeons was improper in that it wished to use a coroner's inquest to get evidence with regard to some disciplinary action. It was his opinion that a coroner's inquest was not the proper forum for eliciting information of that character. The death had occured almost a year and a half before the request was made, and the cause of the death was known. There was no suggestion that the treatment caused the death. When asked by Dr. Shulman whether he had asked for permission to hold an inquest, Mr. Common answered:

> "You might have done, but I never directed you not to hold an inquest by any means." [Page 467 line 29—page 468 line 5]

Mr. Common testified that he did not know the doctor in question or the company whose products he promoted. No outside influence was brought to bear on him or his department in determining that it was advisable not to hold an inquest.

In this matter, I am not concerned with Mr. Common's disagreement with Dr. Shulman as to the proper forum to inquire into the conduct of a physician. Dr. Shulman obviously accepted Mr. Common's advice and the Discipline Committee dealt with the matter. Mr. Common's evidence is supported by Dr. Shulman's own statement in his letter to Dr. Cotnam, and is consistent with what Dr. Shulman is reported to have said to the press. I accept Mr. Common's evidence. It was Mr. Common's duty to see that inquests were not used for improper purposes. Section 17 of the Coroners Act provides:

> "Where the Attorney General has reason to believe that a death has occurred in Ontario *in circumstances that warrant the holding of an inquest*, he may direct any coroner to hold an inquest and the coroner shall hold the inquest into the death in accordance with this Act, whether or not his commission extends to the place where the death occurred or where the body is located and whether or not he or any other coroner has viewed the body, made an investigation, held an inquest or done any other act in connection with the death." [my italics] [R.S.O. 1960, c. 69, s. 17]

The circumstances must warrant the holding of an inquest. The power granted to the Attorney General under the section is discretionary, not mandatory.

It was contended that Mr. Common suppressed an inquest in this matter by refusing to authorize that one be held, as a result of which Dr. X. was permitted to practise medicine until his name was subsequently erased from the register. It is clear however, from the evidence that Dr. Shulman sought advice, received it and followed it. The matter was referred to the College of Physicians and Surgeons which is the only body empowered to discipline the medical profession. That being so, I cannot accede to the submission that there was an unlawful or improper suppression of an inquest with respect to this matter

PADOLIAK INVESTIGATION

On September 30, 1963, in response to a telephone call from Mr. Philip Padoliak, Dr. Shulman visited the home of Mrs. Helen Padoliak, who at that time was suffering from an advanced cancer. In the presence of Dr. Henry Goldenberg, her attending physician, Mrs. Padoliak related to Dr. Shulman, in the form of a statement which was transcribed by his secretary [Exhibit 50], that she and her husband had been negotiating with a man called Dr. V. Mirkovich, who claimed to have a serum which cured cancer. Apparently, a friend of the Padoliaks, Mr. Ivan Romanoff, told them that this serum had been administered upon his wife who had also suffered from cancer, and as a result her condition had improved tremendously.

An attempt was made to secure some of this serum for Mrs. Padoliak, but without success. Dr. Shulman testified that Mrs. Padoliak told him that she had stopped receiving serum injections in August, 1963, because she was negotiating with Mr. Mirkovich. [Page 2859 lines 10-12]

Subsequently, on December 27, 1963, Mrs. Padoliak died, and upon learning of her death Dr. Shulman wrote to Attorney General Cass on January 30, 1964, enclosing Mrs. Padoliak's statement, pointing out that no other body except the Department of the Attorney General could take action, and requesting permission under Section 16 of The Coroners Act to hold an inquest to expose Mr. Mirkovich's activities. [Exhibit 45]. On January 31, 1964, Attorney General Cass replied:

> ". . . the statement she made shortly before her death causes me real concern and I feel that the allegations therein warrant full investigation. However, I am in some doubt as to whether or not the investigation should be by way of inquest or an investigation by the police or by the medical council. If there is any indication that the conduct of Dr. Mirkovich caused or contributed to the death of Mrs. Padoliak, then an inquest would be the proper procedure having regard to Sections 7 and 10 of the Coroners Act. Will you please let me have further advice as to this and also the basis for your view that no other body apparently can take action." [Exhibit 46]

On February 1, 1964, Dr. Shulman wrote to Attorney General Cass, stating clearly:

> ". . . no action can be taken by the College of Physicians because Mr. Mirkovich has taken care that no patients are treated in Canada but must first proceed to Mexico. Similarly I cannot conceive of any police charge being laid as payment is also apparently made outside of this country. I feel that Mr. Mirkovich's conduct contributed to the death of Mrs. Padoliak in that she neglected seeking other treatment while she followed this hopeless trail. By exposing this charlatan other unfortunates can be saved from Mrs. Padoliak's experience." [Exhibit 47]

Following some discussion with Dr. Shulman on this matter, Attorney General Cass wrote to him on February 4, 1964:

> ". . . I have delivered the file to Mr. W. C. Bowman, Q.C., Director of Public Prosecutions, so that he may investigate the matter further and decide whether or not there are any grounds for prosecution under the provisions of the Criminal Code. I shall also refer the matter to the College of Physicians to ascertain whether or not any action can be taken by them." [Exhibit 48]

Upon the instructions of Mr. Bowman, Inspector Grice, a member of the Ontario Provincial Police, launched an investigation into Mrs. Padoliak's death. He recounted that Mrs. Padoliak had heard of Mr. Mirkovich from Mr. Ivan Romanoff. Mr. Romanoff advised Inspector Grice that during the fall of 1960 he and his wife had been in contact with Mr. Mirkovich, who offered them a serum to treat Mrs. Romanoff's cancer. Mr. Mirkovich told them that he could not administer the treatment but that he would supply the serum free of charge to any doctor who would inject it. Mrs. Romanoff obtained the assistance of Dr. Nadia Iwachniuk, and twelve serum shots were given over a period of approximately two months. During the latter part of December, 1960, Mr. Mirkovich ran out of serum and the injections ceased. Mrs. Romanoff subsequently died in February, 1961. Mr. Romanoff stated that they had tried to pay Mr. Mirkovich on several occasions but he had refused to accept money because the amount he required to build a laboratory for the production of the serum would be enormous.

Inspector Grice also interviewed Mr. Philip Padoliak, who told him that upon Mr. Mirkovich's return from Mexico, he and his wife visited Mr. Mirkovich, who requested $100,000 to set up a laboratory. Mrs. Padoliak offered Mr. Mirkovich a couple of thousand dollars but he refused. Mr. Mirkovich did ask them if they knew of any rich cancer patient who would be able to provide the financial backing for the construction of a laboratory.

Mr. Padoliak further stated that several telephone calls and visits took place and on each occasion he asked Mr. Mirkovich about the serum and Mr. Mirkovich told him that he had none of it or that he was attempting to make it and it had been spoiled by bacteria. The Inspector also testified that he had contacted the College of Physicians and Surgeons to ascertain whether Mr. Mirkovich was on the rolls of the College. He learned that Mr. Mirkovich was not a doctor. It was Inspector Grice's conclusion, after having investigated very thoroughly into this matter, that there was no evidence upon which to base any criminal charge. [Page 945 lines 26-30]

On February 18, 1964, W. C. Bowman submitted the Inspector's findings to the Attorney General and reported that:

> "There appears to be nothing illegal in the conduct of Dr. Mirkovich and at the moment at any rate I can't see any point in pursuing the matter further." [Exhibit 52]

The Attorney General did not order that an inquest be held and none was held.

Dr. Shulman's allegation of unlawful or improper suppression of an inquest in this case was general, naming no individual.

The basis of Dr. Shulman's complaint was that, "Mr. Mirkovich's conduct contributed to the death of Mrs. Padoliak in that she neglected seeking other treatment while she followed this hopeless trail".

Dr. Shulman testified that when he visited Mrs. Padoliak on September 30, 1963, she was a very sick woman. [Page 2871 lines 17-19]. He stated that she was not a terminal case at that time. [Page 2871 lines 21-24]. It was Dr. Shulman's opinion that the woman might have lived a considerably longer time if she had continued with her serum injections instead of negotiating with Mirkovich. [Page 2863 lines 23-26]

Evidence was called to show what treatment Mrs. Padoliak received while she attempted to secure serum from Mr. Mirkovich. From the evidence it is not exactly clear when Mrs. Padoliak first began her discussions with Mr. Mirkovich and when they were discontinued. Nevertheless, there is no doubt that the two outside dates were from April, 1963, to November, 1963.

Dr. Cotnam produced the medical records from Mount Sinai Hospital and these were filed as an exhibit [Ex. 50]. He testified that from the records it appeared that Mrs. Padoliak had received quite extensive treatment.

Beginning in January, 1962, she had had a radical mastectomy for cancer of the right breast at the Women's College Hospital. This indicated to Dr. Cotnam that she had a far-advanced cancer. Immediately thereafter she received a course of radiation therapy at the Princess Margaret Hospital. In January of 1963 there was a recurrence of the cancer in the right clavicle. Subsequently, in April 1963, the outside date when she first came into contact with Mr. Mirkovich, she had an ovary removed. This is a recognized treatment in cancer cases of this nature.

During June and July of that year, she also received a series of serum injections from Dr. Gordon Murray. At the end of July, 1963, she contacted Dr. Goldenberg and received treatments in the form of injections from him. He admitted her to the new Mount Sinai Hospital on August 13, 1963. On September 6, 1963, she was discharged from the hospital, at which time her condition was improved. She was essentially pain-free until November, and on December 4, 1963, she was re-admitted to the new Mount Sinai Hospital, where she died on December 27th, 1963.

This evidence would indicate that Mrs. Padoliak was under a physician's care from January, 1962, until her death in December of 1963, and that she was receiving very extensive treatment between April, 1963, and November, 1963.

Dr. Shulman testified that Mrs. Padoliak told him that she stopped receiving serum injections in August, 1963, because she was negotiating with Mr. Mirkovich. While giving his evidence on this point, Dr. Shulman glanced through the hospital records [Ex. 51] and said, "this corresponded with what she told me", that "she stopped receiving serum injections in August because she was negotiat-

ing with this physician. Then she went to Dr. Goldenberg in August when she was admitted to the hospital." [Page 2859 lines 5-13]. Either Dr. Shulman deliberately tried to mislead the Inquiry, implying that the records corroborated his evidence, or he was careless in making a statement without checking the facts when the facts were available in the document he held in his hand. The hospital records clearly indicate that Mrs. Padoliak started treatment from Dr. Goldenberg at the end of July, not on the 13th of August.

The records of Mount Sinai Hospital contain a history that Mrs. Padoliak gave on her admission to hospital on August 13. She said at that time that she saw Dr. Goldenberg at the end of July, that he gave her two injections, "the last shot was last Thursday". [Ex. 50]. This would indicate that she saw Dr. Goldenberg at least twice during this two-week period, once on Thursday, August 8th, and once the week before. This statement given by Mrs. Padoliak about the medical treatment she had received a few days before is probably accurate.

It may be that Mrs. Padoliak did not receive serum injections for a very short period of time while changing from Dr. Murray to Dr. Goldenberg, but there would seem to be very little evidence to support Dr. Shulman's opinion that this contributed to her death. Dr. Cotnam testified after examining her hospital records that it appeared to him that she was under the care of some physician from January, 1962, when she first presented herself with cancer, up until the time of her death, and that she appeared to be a hopeless cancer case even then. The hospital records would appear to bear this out.

In view of the medical history of this unfortunate woman, I prefer to accept the opinion of Dr. Cotnam.

Even if it were proven that Mrs. Padoliak did neglect to undergo treatment while she tried to secure serum from Mr. Mirkovich, I do not think this neglect could be said to be conduct on *his* part which contributed to her death.

However, whether or not Mr. Mirkovich's conduct contributed to the death of Mrs. Padoliak is a matter of pure speculation and is beyond the competency of this Commission to determine. The sole issue is to ascertain if there was any unlawful or improper suppression or interference with investigations or inquests on the part of the Government of Ontario and certain senior civil servants of the Attorney General's Department.

It is clear from Dr. Shulman's evidence that he wished to hold an inquest for the sole purpose of exposing the activities of Mr. Mirkovich. The Attorney General obviously did not think that this would form a legal basis for an inquest and inquired of Dr. Shulman if there was any indication that the conduct of Mr. Mirkovich caused or contributed to the death of Mrs. Padoliak. Dr. Shulman replied that Mr. Mirkovich's conduct contributed to the death of Mrs. Padoliak in that *she* neglected seeking other treatment while she followed this hopeless trail; but he produced no evidence to support this allegation. An investigation was conducted by the Attorney General. The evidence disclosed that she was never treated by Mr. Mirkovich and a check of the hospital records indicated that she was receiving treatment from qualified physicians between April 1963

and November 1963. Dr. Shulman's opinion was based more on presumption than fact. Under these circumstances there could be no justification for calling an inquest.

This case raises once again the difference of opinion between Dr. Shulman and the legal officers of the Crown as to the purpose of an inquest. I have already set out the law as laid down by the Ontario Court of Appeal and need not repeat it. Dr. Shulman's opinion as to the purpose of an inquest is not in accord with the law. On the evidence disclosed I find that there was no unlawful or improper suppression of an inquest in this matter.

BURNETT INQUEST

This particular matter arises from the death of Horace Burnett, aged 71, on July 10, 1963, in the Shouldice Surgery, a private hospital in the City of Toronto. The death was investigated by Dr. E. Cass who decided that an inquest should be held. Dr. Shulman sat in with Dr. Cass and took an active part in the inquest. After hearing the evidence the jury brought in a verdict as to the cause of death and made a series of recommendations regarding the hospital. Counsel for Dr. Shouldice brought a motion to quash in the Supreme Court of Ontario and the verdict was quashed on December 13, 1963.

Dr. Shulman got in touch with F. M. Cass, Attorney General, and requested that the decision be appealed, but the Attorney General agreed with the judgment of the Court and refused to appeal. In January of 1964 both Dr. Shulman and Dr. Shouldice appeared on a television program. Dr. Shouldice stated that he had no intention of following the recommendations of the jury because they were completely unnecessary for his surgery. On December 16, 1964, almost a year later, Dr. Shulman wrote the following letter to Dr. Shouldice [pages 2087 and 2088]:

> "Dear Dr. Shouldice: It is now exactly one year since the inquest into the death of Horace Burnett was quashed. Once an inquest is quashed it legally did not occur and it would have been quite proper for me to order Dr. Cass to hold a new inquest in the case.
>
> Until now I have not done so in order to avoid further unfavourable publicity for your clinic and in the hope that you would carry out several of the jury's recommendations to improve your equipment and pre-operative technique.
>
> I feel that sufficient time has now passed to make a final decision and I would therefore request your reply as to which of the jury's recommendations you have carried out or intend to carry out.
>
> Please be assured that I do not wish to cause you unnecessary difficulties but it was the opinion of the independent expert called as a witness that changes were essential at your surgery.
>
> I am anxious to prevent future unnecessary mortality.
>
> Please advise me at your earliest convenience."

He did not receive a reply from Dr. Shouldice but did receive a telephone call from Mr. Wilson, the Assistant Deputy Attorney General, who, according to Dr. Shulman, advised him that Dr. Shouldice had been in contact with the Prime Minister of Ontario and that Mr. Wishart, the Attorney General, had instructed Mr. Wilson to phone him and tell him that he was to take no further action and not to bother Dr. Shouldice any more. A month later Dr. Shulman wrote to Dr. Shouldice again. His letter reads [page 2089 and 2090]:

> "Dear Dr. Shouldice: It is now five weeks since I wrote to you and although I have not received a reply from you I did get a phone call from an official at the Attorney-General's Department expressing displeasure that I had followed up the case.

I am very disappointed that rather than make those simple changes at the clinic which could prevent future deaths, you would attempt to silence me through the Attorney-General's Department.

Despite this incident, I am still willing to forego holding an inquest to replace the quashed one provided that I receive an assurance from you that at least a portion of the jury's recommendations have been carried out or will be carried out.

I trust that I will receive a more direct reply to this letter."

Dr. Shulman received no direct reply from Dr. Shouldice. On February 10, 1965, he received a letter from the Attorney General, part of which referred to the Burnett inquest as follows [pages 2091, 2092]:

"I also want to draw your attention to your letter of December 16th, 1964, directed to Dr. Shouldice. The inquest into the death of the late Horace Burnett was quashed by a Judge of the Supreme Court of Ontario. This, of course, had the effect of removing any recommendations or allegations that had been made by the jury at the inquest.

Regardless of the question as to your authority to order a new inquest in those particular circumstances your letter appears to direct Dr. Shouldice to advise you as to his compliance or non-compliance with the recommendations which had been quashed or, in the alternative, you were going to undertake to order an inquest and re-open the whole proceeding.

You also make a point of drawing to Dr. Shouldice's attention that you have not directed an inquest up to this time 'in order to avoid further unfavourable publicity for your clinic'. In my opinion, this letter to Dr. Shouldice constitutes a threat that if Dr. Shouldice does not comply with a jury's verdict which has no legal effect whatsoever, then Dr. Shouldice may be subjected to a further inquest with attendant unfavourable publicity. This type of threat by a public servant to a responsible member of our society is, in my opinion, inexcusable, and is inconsistent with your duties as Chief Coroner. If you are under the impression that there are still circumstances which require investigation, then you are most certainly familiar with the procedures under the Coroners Act by which such an investigation may be made in a proper and lawful manner."

Dr. Shulman replied to Mr. Wishart on February 16, 1965, and the portion of his letter referring to the Burnett matter read [page 2093]:

". . . You question my 'authority to order a new inquest in those particular circumstances'. May I have a directive on the matter if it is your opinion that I do not have such authority . . . ?"

Mr. Wishart did not reply to this letter but a meeting was held on April 2. At that meeting there was present in addition to Dr. Shulman, the Prime Minister of Ontario, the Attorney General, the then Deputy Attorney General, Mr. Common and Dr. Cotnam. Dr. Shulman presented his views on this and several other matters relating to the Coroner's office and left a portion of his correspondence with the Prime Minister.

Dr. Shulman gave this case as one in which there had been an unlawful or improper suppression of an investigation or an inquest. The person against whom the allegations were made was Mr. Wishart. Subsequently Dr. Shulman

did not suggest that there was any suppression in holding the inquest, but indicated that the suppression took place later. [Page 592 line 19 to page 593 line 22].

To understand what took place following the inquest it is necessary to have some knowledge of what took place at the inquest, even though the inquest was quashed. Numerous doctors gave evidence. Dr. Alfred Brown and Dr. Georgieviski gave evidence as to the pre-operative examination; Dr. Shouldice and Dr. Obney as to the operation. Dr. VanPatter testified as to the autopsy. Dr. Stalker had inspected the Shouldice Clinic on various occasions and testified that the clinic conformed to the regulations of the Ontario Hospital Act. Dr. Gordon Campbell, a surgeon from the McGregor Clinic in Hamilton, gave opinion evidence as to the equipment and facilities at the Shouldice Clinic, based on what he had heard in evidence. It was Dr. Campbell's opinion that the facilities were primitive. It was also his opinion that an anaesthetist should be in attendance at all hernia operations.

Dr. Roderick A. Gordon, B.Sc., M.D., F.R.C.P. (Canadian), F.F.A.R.C.S., F.A.C.A., a professor of anaestheology at the University of Toronto, consultant of the Canadian Forces, a member of the Medical Council, on the staffs of the Hospital for Sick Children, the Women's College Hospital and Sunnybrook Hospital, after hearing the evidence of Dr. Obney and Dr. Shouldice, felt that a local anaesthetic was a satisfactory anaesthetic for an operation of this type and that resuscitation equipment was not necessary or customary. Dr. Robson, a certified anaesthetist, was also called as an expert. He was familiar with the local anaesthetics used at the Shouldice Surgery from observation. It was his opinion that it was not necessary to have an anaesthetist present at each operation when the surgeon administered a local anaesthetic. Dr. Shulman disagreed with both these opinions.

While giving evidence at the hearing, Dr. Shulman stated that Mr. Burnett died of natural causes. He further stated that there was no question of the doctor's surgical competence. [Page 2124 lines 29 and 30].

In Dr. Shulman's summation to the jury as taken from page 178 of the inquest evidence, he said:

> "I may say quite definitely from the evidence that there has been no question whatsoever of any negligence or malpractice." [Page 2151 lines 19-22]

The verdict of the jury was:

> "We the Jury, find from the evidence submitted that Horace Leslie Burnett, Age 71 came to his death at 10:35 p.m. July 11, 1963 in the Shouldice Clinic, 626 Church Street from acute bilateral lobar and confluent pneumonia (pneumococcal) with pulmonary oedema, and coronary heart disease (a probable contributory factor).
>
> We the Jury, are of the opinion that in view of the evidence provided that certain recommendations be made in regard to the treatment of the patient preoperatively, operatively, and post-operatively.
>
> Preoperatively we recommend a more intensive clinical and laboratory examination be undertaken.

Operatively we recommend that a certified anaesthetist be available and present particularly in those cases which present an emergency. Also we recommend that a complete emergency armamentarium be available for immediate use.

Post-operatively we recommend that a resident Doctor be employed if possible to handle unforeseen emergencies.

We recommend that legislation be passed that all existing hospitals clinics etc. be brought up to the recognized standards of accreditation." [Exhibit 127]

The inquest held was open to the public, and the verdict and recommendation received great publicity. Recommendations of coroners' juries, while often helpful in preventing further deaths, have no legal effect. In this inquiry I am not concerned with whether the recommendations were good or bad. I am concerned only with whether there was any illegal or improper suppression of evidence in relation to this inquest.

On January 21, 1964, when both Dr. Shouldice and Dr. Shulman appeared on television, Dr. Shulman, when questioned in relation to this particular inquest, was reported as follows:

Q. Is it not possible for you as Chief Coroner in this district to re-open an inquest into this same subject?

A. Yes, this inquest could be opened again. A new inquest could be held but frankly I don't see that there would be any point as we already have all the facts and the jury did not censure anyone and there was no question of Dr. Shouldice's competence. They did make certain recommendations of improvements and I can't see them going all through it again would really add anything." [Page 2177 lines 4-21]

At the hearing a question was raised as to whether the last sentence of this quotation was correctly reported, but there is no dispute that recommendations were made.

At the inquiry Dr. Shulman agreed that he told the interviewer that there would not be any point in holding another inquest as "we already have all the facts". He agreed that he said there was no question of Dr. Shouldice's competence. He agreed that the jury had made certain recommendations and that he could not see that going through another inquest would really add anything. [Page 2179 line 14 to page 2180 line 6]

Dr. Shouldice was reported as saying at the time that he had no intention of following the recommendations because they were completely unnecessary for his Shouldice Surgery on Church Street. Dr. Shulman saw and heard these remarks.

Although Dr. Shulman on the television program had said that there would be no purpose in having an inquest as all the facts were known and recommendations had been given, he wrote to Dr. Shouldice on December 16, 1964, and said in effect: "If you don't go ahead with these recommendations I will give you more unfavourable publicity by holding another inquest."

Dr. Shulman agreed that a jury's recommendations are purely recommendations. They have no legal effect. [Page 2098 lines 29 and 30]. He agreed that there was no legal procedure by which he could force Dr. Shouldice to carry out the recommendations. He tried to accomplish by threat what he could not accomplish legally. He stated that he felt his actions were justified if by so doing he might save a third person's life. Whether they would or not is a matter of opinion. It is quite clear that Dr. Shouldice did not believe that these recommendations would save lives. On the contrary, he felt that they were ridiculous and some of them were impossible to carry out. Dr. Shulman agreed that Dr. Shouldice was a much better surgeon than he was but he would not agree that in this particular aspect of the matter Dr. Shouldice's opinion should bear at least equal weight with his own.

Dr. Shulman testified that following this letter to Dr. Shouldice he received the phone call from Mr. Frank Wilson, the Assistant Deputy Attorney General. Mr. Wilson stated that this case arose prior to his appointment as Assistant Deputy in March of 1964, that he had had numerous telephone discussions with Dr. Shulman about various matters at that time, but he had no recollection of having discussed the Burnett matter. He did not recall having received any instructions in the matter from his superiors but I am satisfied that he was talking to Dr. Shulman and did pass along the Attorney General's displeasure at Dr. Shulman's conduct. There is nothing sinister or improper in telling an employee not to do something he has no right to do.

In the second letter written January 22, 1965, Dr. Shulman still held the threat of an inquest over Dr. Shouldice's head. Dr. Shulman then received the letter from the Attorney General dated February 10. The views of the Attorney General were quite clear. He felt that this type of threat by a public servant was inexcusable and inconsistent with the duties of Chief Coroner.

One sentence from Dr. Shulman's letter of December 16, 1964, to Dr. Shouldice, deserves comment. He wrote:

> "Once an inquest is quashed it legally did not occur and it would have been quite proper for me to order Dr. Cass to hold a new inquest in the case." [Page 2087 lines 18-22]

The Attorney General obviously did not share this opinion, for in his letter of February 10, 1965, he said:

> "Regardless of the question as to your authority to order a new inquest in those particular circumstances . . . ." [Page 2091 lines 19-21]

Dr. Shulman seemed to think that Section 3 (1) of the Coroners Act gave him power to interfere. Section 3 (1) provides:

> "The Lieutenant Governor in Council may appoint a coroner, to be known as as chief coroner, for any city having a population of more than 100,000, who shall have control over the coroners for the city and who shall have such other powers and perform such other duties as the regulations prescribe. [R.S.O. 1950, c. 70, s. 3(1)]

But Section 10(3) follows Section 3(1) and does not except it.

Dr. Shulman's opinion as to the law would seem to be contrary to Section 10(3), which reads:

> "After the issue of the warrant no other coroner shall issue a warrant or interfere in the case, except the supervising coroner or except under the instructions of the Attorney General or the Crown Attorney."

Had the legislation intended to give the Chief Coroner the same powers as the Supervising Coroner for Ontario or the Attorney General, the Chief Coroner would have been mentioned in Section 10(3).

It is my opinion that when a warrant was issued by Dr. Cass, only Dr. Cass could decide whether to proceed with the inquest, subject only to intervention by the Supervising Coroner, or under the instructions of the Attorney General or the Crown Attorney.

Mr. A. R. Dick, Deputy Attorney General of the Province of Ontario since November 23, 1964, produced all correspondence of the Attorney General's Department in relation to the death of the late Mr. Burnett. The first reference was a letter from J. J. MacKay, the Managing Director of the Shouldice Clinic, to the Attorney General, enclosing a copy of a letter written by Dr. Shulman to Dr. Shouldice, which has already been referred to, and a copy of the letter written by Dr. Shouldice to The Honourable John P. Robarts, Prime Minister of Ontario. The Prime Minister referred the letter to the Attorney General's Department. It related to a coroner and therefore fell within the Attorney General's department. The attached memorandum, dated February 1, 1965, read:

> "May I have your comments on this please as soon as possible." [Page 2225 lines 12-14]

This was normal procedure and there is nothing to suggest he did more than this. The Attorney General then wrote the letter dated February 10, 1965, to Dr. Shulman, and this letter has previously been set forth.

The file also contained a confidential memo from Mr. Dick to the Attorney General relating to the Burnett case. Mr. Dick, following the meeting with Dr. Shulman previously referred to, had been asked to look into the allegation of Dr. Shulman of interference by the Attorney General's department and to report to the Attorney General. The memorandum read as follows:

> "Inquest respecting H. L. Burnett,
> deceased—died July 10th, 1963.
>
> Dr. Elie Cass investigated the death of this man at the Shouldice Clinic. Dr. Cass issued a warrant and found the cause of death was pneumonia and coronary heart disease. Dr. Cass presided at the inquest, but Dr. Shulman played a prominent part in the proceedings. An application was made by the solicitor for Dr. Shouldice, by way of certiorari proceedings and Mr. Justice Richardson of the Supreme Court subsequently quashed the inquest, since the Chief Coroner had assumed jurisdiction contrary to the provisions of Section 10(3) of the Coroners Act. Counsel from this department sought to uphold the inquest on the basis that the remedy was discretionary and that the applicant was not an interested party. However, we did have to admit

that there had been a violation of the Section, and the judge consequently quashed the inquest.

I do not believe there is or could be any allegation of interference in this particular case, and no appeal was possible because there was no basis for an appeal." [Page 2227 line 21 to page 2228 line 20]

The reference in the last paragraph of the memorandum is to Dr. Shulman's allegation of interference by the previous Attorney General when he refused leave to appeal. Dr. Shulman argues that the Attorney General interfered by not appealing a decision which the Deputy Attorney General said should not be appealed. The latter's reason was that the decision of the judge was based on the grounds that the Chief Coroner had assumed jurisdiction contrary to the provisions of Section 10(3) of The Coroners Act. I do not think any reasonable person could infer that this so-called interference was an unlawful or improper suppression of evidence.

In deciding whether the instructions of the Attorney General, given over the telephone by Mr. Wilson to the Chief Coroner, were interference which amounted to unlawful or improper suppression of evidence, it must be considered that the Supreme Court of Ontario had already held that the Chief Coroner had interfered in the Burnett inquest contrary to Section 10(3) of The Coroners Act, that the former Attorney General had refused to appeal the decision because there was no disputing the fact that Dr. Shulman had interfered, that Dr. Shulman had already stated that no further inquest was necessary, and that Dr. Shulman was using the threat of possibly adverse publicity from a second inquest in an attempt to force Dr. Shouldice to carry out recommendations of a jury that had no legal effect. If the Attorney General honestly believed that Dr. Shulman's conduct was improper, then not only was it proper for the Attorney General to so advise Dr. Shulman, and to tell him to desist; it was his duty to do so.

It was submitted by counsel for Dr. Shulman that the evidence disclosed a contempt or indifference with regard to the merits of the recommendations of the jury, and to the objective of protecting the public and reducing mortality, an anxiety to avoid another inquest, zealous concern to protect the wounded pride of Dr. Shouldice and the interests of his successful private enterprise. With great respect to the submission of counsel, in my opinion it completely misses the real issue. The issue in this matter was: Can a coroner threaten an individual with the adverse publicity of an inquest where he has no right in law to hold an inquest? The answer must surely be "No". Dr. Shulman threatened to hold an inquest in this case, where an inquest had already been held, where he said there was no evidence of negligence or malpractice, and where he himself acknowledged that there was no point in holding one.

This does not conform to the standard of justice which commends itself to me. It is foreign to those basic principles which protect the rights of the individual, which rights should not be encroached upon except by due process of law.

MULHOLLAND INQUEST

This case was given by Dr. Shulman as one in which there was an unlawful or improper suppression of evidence in relation to an inquest. Mr. Wilson and Dr. Cotnam were the persons against whom the allegation was made.

Mrs. Adriana Mulholland died on October 30, 1964. The investigating coroner was Dr. S. J. Evelyn. Detective Sergeant Ryan attached to the Arson Squad of the Metropolitan Toronto Police Force was in charge of the police investigation. It was at first thought that a fire at her home had caused the death, but a post-mortem examination by Dr. Gupta, a pathologist, disclosed an over-dose of barbiturates. John Gaspardi, a house-boy who had discovered the fire, was subsequently charged by the police with fraud and he disappeared while out on bail.

Dr. Shulman stated that when no inquest had been held by the end of the year, he got in touch with Dr. Evelyn and instructed him to hold one. The inquest began on March 3, 1965. Mr. Frank Wilson, the Assistant Deputy Attorney General, was appointed Crown Counsel. All witnesses were heard at the inquest, with the exception of Gaspardi who could not be found. Dr. Shulman spoke to Mr. Wilson and suggested that the inquest be adjourned *sine die.* According to Dr. Shulman Mr. Wilson demurred but did adjourn to March 15. Dr. Shulman said he wanted the inquest adjourned *sine die* because it appeared to him that either the boy had started the fire to cover perhaps a murder, or alternatively that he was completely innocent.

When the inquest reconvened on March 15 Gaspardi was still not available. Dr. Shulman then asked Mr. Wilson to adjourn the inquest for three months, but he disagreed and said the Attorney General could always order another inquest if new evidence turned up. The inquest was then completed and the jury brought in a verdict as follows:

> "We the Jury say that Adriana Mulholland came to her death at 4.05 A.M. October 30th, 1964, from the effects of an over-dose of sleeping pills.
>
> Adriana Mulholland came to her death at 4.05 A.M. in the forenoon on the 30th day of October 1964, at 684 Oriole Parkway, Toronto.
>
> At this time, March 15th, 1965, from the evidence available and bearing in mind the fact that one witness is missing, we attach blame to no person, but it is strongly recommended by this Jury that Bela John Gaspardy [*sic*] be apprehended for further questioning." [Page 881 lines 4-19]

Subsequently the police advised Dr. Shulman that they had found the boy. On May 5, 1965, Dr. Shulman wrote the following letter to Dr. Cotnam [page 2832]:

"Dear Dr. Cotnam:

Re: Mulholland Inquest.

You will recall that this inquest was concluded without hearing the key witness, Gaspardy, who was not available.

The jury brought in a verdict casting a serious aspersion on this young man.

As Gaspardy is now in custody I would recommend that the inquest be re-opened so as to allow him the opportunity to clear his name." [Page 2832 lines 18-30]

Dr. Shulman stated that he received no reply to this letter.

Dr. Shulman was referred to a report in the *Globe and Mail* of May 6, 1967, which purported to quote from his Brief:

"An inquest was closed over my objection, at the insistence of the Assistant Deputy Attorney General. Subsequently important new evidence became available which could have determined whether the death was accidental or homicidal. The Attorney General's Department would not re-open the inquest." [Page 2834 lines 12-23]

Dr. Shulman agreed that this was in his Brief. He was then asked what new evidence became available which could have determined whether the death was accidental or homicidal. He replied:

"Mr. Gaspardy was the only person present. He was present to give the evidence and could present it." [Page 2836 lines 10-12]

Detective Sergeant Ryan had previously testified that the statement Mr. Gaspardi gave to the police on his return was the same as he had given before he left, so that the evidence that became available was no different than the evidence given at the inquest by the police officer.

Dr. Shulman was then asked:

Q. And you are suggesting he should have been put under oath at that inquest to prove his innocence?

A. He should have been put under oath to clear his name and to prove his innocence, yes, sir. [Page 2838 lines 18-23]

Detective Sergeant Ryan testified that he saw Gaspardi at 10:50 A.M. on the morning of the fire at the home of Mrs. Fisher, daughter of the deceased. Gaspardi told him that he had been out the night before and returned home about 2:00 A.M. He went to bed in his own bedroom in the basement of the house and listened to the radio but was unable to sleep. About 3:40 A.M. he went upstairs to the kitchen on the main floor. He smelled an odour and then saw smoke coming from the bedroom at the rear of the house which was occupied by Mrs. Mulholland. He opened the door and could see smoke and flames. He shouted to Mrs. Mulholland, ran to Mr. Mulholland's bedroom and awakened him, then went to the den and telephoned for help. Detective Sergeant Ryan

subsequently learned that Gaspardi had already been interviewed by Detective Sergeant Follis and Detective Sergeant Locock and had given them the same story.

Detective Sergeant Ryan stated that subsequent investigation indicated fraud on the part of Gaspardi and he was arrested on October 31, appeared in Police Court on November 2 and was released on bail. Gaspardi was to appear for trial on November 10 but left the jurisdiction before that date. When the inquest commenced on March 3 his whereabouts were not known. Detective Sergeant Ryan gave evidence at the inquest and told the jury what had been told to him by Gaspardi.

Gaspardi returned to Toronto and was picked up by the police on May 3. Detective Sergeant Ryan testified that he questioned Gaspardi further about the fire at that time but his evidence was still the same. He stated that the police have received no information since the inquest that was in any way different from the evidence given at the inquest. His investigation produced no evidence that would contradict Gaspardi or implicate him in any way with the death of Mrs. Mulholland.

Mr. F. L. Wilson testified that shortly before his appointment as Crown Counsel on this inquest he was given particulars of the death by Mr. Hills. He received a Brief from the Toronto Police Department. He called all the witnesses listed in the Brief. These included the policeman who had received the call and attended at the premises, one of the firemen who attended the call and the daughter of the deceased, Mrs. Fisher, who testified that her mother was in the habit of resting in the afternoon and did smoke on these occasions. Testimony was also given by the family physician who had prescribed a drug for aiding sleep for Mrs. Mulholland, and by the pharmacist who filled the prescription. Detective Sergeant Ryan gave evidence regarding his investigations and his interview with Gaspardi.

Mr. Wilson stated that all evidence was given at the inquest except the reference to fraud. It was Mr. Wilson's opinion that since the charge against Gaspardi had not been disposed of by the courts, this information should not be placed before the inquest jury. It was also his opinion that Gaspardi should not be forced to testify against himself. Mr. Wilson stated that when Dr. Shulman suggested to him at the conclusion of the testimony that the inquest be adjourned *sine die* in order that Gaspardi could be called, he took the position that the adjournment should not be *sine die* but to a day certain, that there was nothing in the police report or in the evidence to indicate that Gaspardi was involved in the death and that if any new evidence did become available the Attorney General could direct another inquest. He was merely trying to comply with what he believed to be the law.

At the adjourned hearing Dr. Shulman submitted that the inquest be adjourned for a further period of three months. Mr. Wilson stated that he then repeated that all the relevant evidence had been called, that evidence similar to what Gaspardi could give had already been given to the jury, and if any new evidence became available the Attorney General could direct another inquest.

He submitted his views to the coroner for consideration. Dr. Evelyn discussed the procedure with Dr. Cotnam who advised him that the decision was for him. Dr. Evelyn then decided to complete the inquest. Mr. Wilson then summed up to the jury and they delivered their verdict.

On May 25 Mr. Wilson received a letter from Deputy Chief of Police Simmonds, which read as follows:

> "With reference to an inquest which was held in March, 1965, regarding the death of the above-named woman, I wish to advise you that Bela John Gaspardy [*sic*], who was to be a witness at that inquest, was arrested on May 3, 1965, by officers of this Department on charges of fraud and theft.
>
> When questioned by the investigating officers regarding the fire which occurred at 684 Oriole Parkway, Gaspardy gave the officers the same statement which he had previously given at the time of the fire, of which you have a copy.
>
> No further information has been obtained that would indicate that this fire was other than accidental." [Page 887 line 14 to page 888 line 1]

Mr. Wilson stated that he was not aware of any new evidence which had become available which could have determined whether the death was accidental or homicidal. Following receipt of the letter from Deputy Chief Simmonds, Mr. Wilson forwarded his report to the Attorney General, dated June 10, 1965, as follows:

> "In his brief memorandum the Deputy Chief of Criminal Investigation Branch for the Metropolitan Toronto Police indicates that there is no further information available as a result of subsequent investigation and discussions with Gaspardy, and there would appear to be no need, therefore, to re-open the investigation." [Page 892 line 23-30]

Dr. Cotnam testified that he was not present at the inquest on March 3 but attended on March 15. At that time a discussion took place between Dr. Shulman, Mr. Wilson, Dr. Evelyn, Mr. Hills and himself as to whether the inquest should be adjourned again. Dr. Shulman wanted the inquest adjourned for three months. Dr. Cotnam stated that he did not feel that this was necessary since all the available evidence had been heard and there was no reason why the inquest could not be concluded that night. He stated that he was not trying to cover up any possible criminal activities on the part of Gaspardi, who had already been charged and had left the country. There was no way of knowing when he would return, if ever. It was his opinion that if further information was obtained subsequently which would justify another inquest, then another inquest could be held under Section 17 of the Coroners Act.

Dr. Cotnam stated that some months after the inquest he learned from Mr. Wilson that Gaspardi had been picked up by the police, that his statement was the same as previously, and that no new evidence was available. At that time it was decided that a further inquest was not necessary.

Dr. Shulman was asked whether, following the inquest on March 3, he had telephoned Mrs. Fisher, daughter of Mrs. Mulholland, and asked her if she was satisfied with the way the inquest had been conducted and suggested that there was a cover-up. Dr. Shulman stated that he did not recall calling Mrs. Fisher.

Detective Sergeant Ryan testified that as a result of a telephone call he received from Mr. Donald Mulholland, a son of the deceased, on March 6, informing him that Dr. Shulman had been in touch with his sister, Mrs. Fisher, and had suggested that there was a cover-up, he attended at Dr. Shulman's office and discussed the matter with him. Dr. Shulman admitted that he had telephoned Mrs. Mulholland's daughter. He was unable to give Detective Sergeant Ryan any evidence that had not been brought out at the inquest. He suggested possibilities that could have happened, but they were only possibilities. He had no evidence to support them. Dr. Shulman at the inquiry was asked whether he had suggested to Detective Ryan that there was a cover-up in this case. His answer and subsequent questions and answers were as follows:

Q. Well, did you not suggest to Dr. Shulman that there was a cover-up in this case—to Detective Ryan; I am sorry?

A. I certainly felt there was a cover-up, yes.

Q. You felt there was a cover-up?

A. Yes.

Q. That somebody was protecting somebody from being involved in a criminal case?

A. I felt the inquest was being covered up or swept under the rug. I think those are the words I used. [Page 2845 lines 9-20]

Dr. Shulman produced no evidence at the inquiry to substantiate his allegation of cover-up. As for the allegation in his Brief, quoted in the *Globe and Mail*—

> "Subsequently important *new* evidence became available which could have determined whether the death was accidental or homicidal." [my italics].

—this was not true. Neither Dr. Shulman nor the police were able to produce any "new" evidence. The fact that Gaspardi was subsequently arrested and could have been subpoenaed was not new evidence relating to the death of Mrs. Mulholland. The statement he gave to the police at that time was the same as the statement given previously, so the evidence relating to Mrs. Mulholland was the same.

Dr. Shulman's allegation that Mr. Wilson was attempting to cover up or suppress facts by not consenting to Dr. Shulman's request to adjourn *sine die* is a malicious allegation. Once again Dr. Shulman tried to do something that was not in accord with the opinion of Crown Counsel. For a Crown Counsel to give an opinion as to what he believed to be the law, that a Coroner's Court being one of record should be adjourned to a date certain, is not a suppression of evidence. It is not a cover-up.

Although Dr. Shulman suggests that Mr. Wilson and Dr. Cotnam were guilty of suppressing evidence because they did not follow his advice and adjourn an inquest for a further three months, it should be pointed out that the decision was made by the Coroner. It is the duty of Crown Counsel to take a position and to make submissions. The evidence indicates that Mr. Wilson brought out all the evidence at the inquest that was available at that time. He advised against an adjournment where a witness had already made a statement that had been read

to the jury. He pointed out that if new evidence became available that the Attorney General could order a new inquest. I do not think this is an unlawful or improper suppression of evidence in relation to an inquest.

Dr. Shulman argued that Gaspardi should be given the opportunity to clear his name. It is not the purpose of an inquest to decide guilt or innocence. No charge was made against Gaspardi relating to the death of Mrs. Mulholland, so he had nothing to answer to in this regard. It was Dr. Shulman who suggested to Sergeant Ryan that Gaspardi might be involved in a homicide and obviously Dr. Shulman wished to use an inquest to decide this issue. The proper place to conduct criminal trials is in the criminal court, not in a coroner's inquest. Dr. Shulman's allegations in this matter were unjustified and unsubstantiated. There was no unlawful or improper suppression of evidence in relation to this inquest.

DODDATTO INQUEST

This matter was put forward by Dr. Shulman on Thursday, May 4, 1967, as one involving unlawful and improper suppression of evidence in relation to an inquest. [Page 592 line 19—page 603 line 6]. The allegation was specifically made against the Attorney General. The following day Dr. Shulman asked to remove this case from the list because it was a political matter and I had previously intimated that I did not wish to become involved in matters that were purely political.

The allegation having been made and not withdrawn that a member of the government had unlawfully and improperly suppressed evidence, I decided that I had no choice under the Terms of Reference but to inquire into and report on the facts on which the allegation was based.

Mrs. Marie Doddatto died in a motor vehicle accident on December 4, 1966. Investigation of her death was assigned in the usual way by the clerk on duty to Dr. Noble, a coroner of five years' standing. The coroner issued his warrant to take the body and arrange for an autopsy to be held.

After the investigation had been assigned to Dr. Noble, Dr. Shulman learned that the driver of one of the motor vehicles involved in the accident was Mr. Donald MacDonald, a Member of the Legislative Assembly for Ontario. When he read a report in the press in which Mr. Henry Bull, the Crown Attorney for the County of York, was quoted as saying that "there was no evidence on which to lay a charge arising out of the accident", Dr. Shulman instructed Mr. Wagner, his assistant, to call Dr. Noble advising him that Dr. Shulman himself would like to conduct the inquest. He also instructed Mr. Wagner to contact the Supervising Coroner's office to secure permission for the transfer.

Dr. Shulman testified that Mr. Wagner told him that he spoke to Mr. Hills and the request was granted, but the following day Mr. Wagner informed him that Dr. Cotnam had called and said that the Attorney General wished Dr. Shulman to write a letter requesting the transfer of authority. Dr. Shulman testified that he had made similar requests to the Supervising Coroner's office on previous occasions and his request had never been refused.

Mr. Hills testified that when he received a telephone call from Mr. Wagner informing him that Dr. Shulman wished to take over the Doddatto inquest, he advised Mr. Wagner to submit the request in writing. This was the normal procedure. He stated that although on occasion requests might be preceded by a telephone call, such requests were always made in writing also. The usual request in Metropolitan Toronto was to transfer a case from one coroner to another because of a conflict of interest. Dr. Shulman took very few inquests and it was very unusual to receive a request to transfer an inquest to him. Following his

telephone conversation with Mr. Wagner, Mr. Hills spoke to Dr. Cotnam about the request. They felt that the matter should be conducted routinely, that is, that the original coroner assigned should continue with the matter. If Dr. Shulman were to take over this inquest from Dr. Noble it might appear to the public that Mr. MacDonald was receiving special treatment. Dr. Cotnam therefore withheld his consent to the transfer but instructed Mr. Hills to point out to Dr. Shulman that he could if he wished write to the Attorney General for permission under Section 10(3), which provides:

> "After the issue of the warrant, no other coroner shall issue a warrant or interfere in the case, except the supervising coroner or except under the instructions of the Attorney General or the Crown Attorney."

Dr. Noble testified that shortly after he was assigned to the investigation he received a telephone call from Mr. Wagner advising him that Dr. Shulman would like to conduct the inquest. Dr. Noble stated that he then received a call from Dr. Cotnam inquiring whether he had been assigned in the normal way and whether he had issued his warrant. When he advised Dr. Cotnam that he had, Dr. Cotnam instructed him to carry on with the case. Dr. Noble then received a telephone call from Dr. Shulman asking him whether he had issued his warrant. He replied that he had. Dr. Shulman then wanted to know if anybody knew that he had issued it. He replied that Dr. Cotnam knew. No explanation was given by Dr. Shulman as to why he asked this question. Because of the conflicting instructions from his two superiors, Dr. Noble then wrote to the Attorney General requesting a ruling as to what he should do.

Dr. Cotnam testified that when Mr. Hills told him of Dr. Shulman's request he did not approve of it. He stated that although a great number of inquests are conducted each year in Toronto, very few were conducted by Dr. Shulman. To have Dr. Shulman take over an inquest involving a well-known public figure might give a wrong impression to the public. He therefore refused to give his consent to the transfer but instructed Mr. Hills to point out to Dr. Shulman that if he still wished to take the inquest he could apply in writing to the Attorney General under Section 10(3) of the Coroners Act, heretofore set out.

Dr. Shulman, in testifying at the inquiry, said that after Mr. Wagner conveyed Dr. Cotnam's message to him he wrote the following letter on December 9, 1966 [pages 1447 and 1448]:

> "Dear Mr. Wishart: Re Mary Doddatto, deceased.
>
> Mrs. Doddatto was killed in a car accident on Highway 401 on December 4th in which Mr. Donald MacDonald was involved.
>
> The case was originally investigated by Dr. A. Noble. I am sorry that Dr. Noble, although very conscientious, is not as capable as we might wish in handling inquests in which complications might arise.
>
> Because of Mr. MacDonald's involvement there will be a close public scrutiny of this inquest, and I am very anxious that nothing should occur that would cast disrepute on the coroner's system.
>
> Therefore after receiving Dr. Noble's approval, my assistant requested a transfer of the inquest under Section 10 to myself. Requests for such

transfers have always been granted routinely in the past and Mr. Hills informed Mr. Wagner the request would be granted in this case. Today, however, Dr. Cotnam instructed Mr. Wagner that I was to write to you setting out the facts and making an official request for the transfer.

I would appreciate your assistance in this matter.

Yours truly,

Morton Shulman."

The Attorney General replied to Dr. Shulman's letter on December 12, 1966, as follows [page 1449]:

"Dear Dr. Shulman:

I acknowledge receipt of your letter of December 9th. Since Dr. Noble is already seized of this matter I would be most reluctant to make any change in regard to the conduct of the inquest. As you state, Dr. Noble is very conscientious and I am sure he will handle the inquest in a capable and satisfactory manner.

I appreciate that, by reason of Mr. MacDonald's involvement, there will be a close public scrutiny. Nevertheless, I feel that we should handle the matter exactly the same as any other inquest, and I have every confidence that Dr. Noble will see that the inquest is carried out in a thorough and capable way.

I appreciate your interest but, in the circumstances I would not be prepared to remove the matter from Dr. Noble's jurisdiction.

Yours sincerely,

A. A. Wishart,

Minister of Justice and Attorney-General."

Dr. Shulman admitted that on his instructions it was the rule in Metropolitan Toronto that no assignment was to be made of any investigation into a death resulting from a motor vehicle accident on a four-lane highway until he was informed. The work sheet produced by Mr. Wagner from the Coroner's office indicates that Dr. Shulman was informed of this death before Dr. Noble was assigned, and that he was advised of the place of the accident and the circumstances of the death, but not of the names of the drivers of the cars involved. He then authorized the clerk to assign the case in the routine fashion. It was only when Dr. Shulman learned that Mr. MacDonald was a driver of one of the cars involved that he endeavoured to take over. Dr. Shulman admitted that it was because Mr. MacDonald was the driver of one of the cars involved that he wrote to the Attorney General on December 9. [Page 1470 lines 22-27)

Dr. Shulman testified that after writing to the Attorney General requesting permission to take over the inquest he received a telephone call from Mr. McKee, a reporter with the *Toronto Daily Star*, who informed him that he had information that prior to the accident the Provincial Police had made a request for sanding because the highway in the area was very slippery. According to the information the sanding had not been done and the police were quite upset about

it. Dr. Shulman didn't ask Mr. McKee for the source of his information but wrote a letter to the Attorney General dated December 10, as follows [page 1449]:

> "Please ignore my letter of December 9th, 1966. Since sending it I have received further information which has resolved the problem.
>
> Sorry to have troubled you.
>
> Yours truly,
> Morton Shulman."

The "further information" that Dr. Shulman was referring to was the information he had received from Mr. McKee. [Page 1449 lines 13-18]. Dr. Shulman testified that following this phone call he went to the office of the Provincial Police at Downsview and spoke to a number of officers there. He inquired whether they had any information about a request for sanding, but they had none. He then called Mr. McKee and asked for his source of information, but according to Dr. Shulman, Mr. McKee said, "Sorry, he will not allow me to release his name." Dr. Shulman then knew that the information he had received from Mr. McKee was unsubstantiated rumour. Dr. Shulman knew that such a rumour was not evidence. His own testimony indicates this. When asked why he did not tell Dr. Noble or the Crown Attorney of his conversation with Mr. McKee, Dr. Shulman replied, "I didn't have any evidence". [Page 1463 line 14]

Dr. Shulman was referred to his letter of December 10 in which he said, "I have received further information which has resolved the problem", and asked how Mr. McKee's evidence had resolved his problem. He answered: "Because it suddenly became clear to me or at least I had a grave suspicion that I understood why the Attorney General intervened to prevent my taking over the inquest. He didn't want the Department of Transport's negligence revealed." [Page 1473 lines 15 to 21]. This incredible statement indicates that Dr. Shulman was prepared to base his suspicion on a rumour from an unknown person who refused to give his name. On this basis he was prepared to deduce that the Department of Transport was negligent, that the Attorney General knew this and that the Attorney General "intervened" to prevent Dr. Shulman from taking over the inquest. I have difficulty in following Dr. Shulman's reasoning, but that is the way he put it. This was a baseless allegation which could only be nurtured in a mind governed by suspicion and not by reason.

The inquest was conducted by Dr. Noble on January 5, 1967. Dr. Shulman was present as was Mr. MacDonald and his counsel. Dr. Shulman admitted that he knew of no witness who was not called [page 1496 lines 12-14] and agreed that the proceedings were conducted impartially. [Page 1496 lines 25-27]. No complaint was made by Mr. MacDonald or his counsel either to Dr. Shulman or to Dr. Noble as to the manner in which the inquest was being conducted. Dr. Noble testified that all the witnesses were called that he was aware of. He stated that he did hear of something about sanding but did not feel it relevant since the evidence of the investigating police officers was that the roads were dry. Only one witness said he thought the road was damp.

Mr. E. J. Sheppey, a former constable with the Traffic Squad of the Ontario Provincial Police, Downsview Detachment, testified that on December 4,

1966, he investigated the death of Marie Doddatto. His report contains the following [page 2396, 2397]:

> "On Sunday, December 4th, 1966, at 6:42 P.M., while on patrol in Departmental automobile 5196 I came upon a motor vehicle accident on Highway 401 west of the Kipling Avenue underpass.
>
> The accident occurred at 6:40 P.M., Sunday, December 4th, 1966, on Highway 401 westbound lanes at a point two miles west of Kipling Avenue underpass, Etobicoke Township, York County.
>
> The roadway at this point is 23 feet wide, two lanes, divided by clearly-visible broken white lines.
>
> Road: dry
> Weather: clear
> Visibility: good
> Light condition: dark
> Speed limit: 60 miles per hour."

This would indicate that the police officer arrived on the scene within two minutes of the accident itself, and noted in his report that the road was dry, the weather clear and the visibility good. He stated that a few days after the accident he was told by Staff Sergeant Craig that Dr. Shulman had been at the office making inquiries. The Staff Sergeant asked him if he had requested sand, or knew anyone who had. Constable Sheppey replied that he had not, then checked the radio log to see if anyone called in requesting sand. He said there was no entry in the records of the Ontario Provincial Police as to any requests for sanding. Constable Sheppey testified that sanding would have had nothing at all to do with this accident, since on the day of the accident the pavement was dry.

There was no evidence at the inquest about the lack of sanding at the site. Dr. Shulman admitted that he had no evidence other than what Mr. McKee had told him. [Page 1492 line 25]. The jury returned the following verdict:

> "We, the jury feel that there was a lack of control or preoccupation on the part of the driver of the MacDonald car. We also feel that the median was inadequate and that it did not afford sufficient protection for oncoming traffic."

After the verdict of the jury Dr. Shulman was reported in the *Globe and Mail* as saying:

> "He wanted to stress 'that this accident was carefully and lengthily investigated. All the evidence indicated that it was a completely unavoidable accident and the car went out of control as the result of striking a depression in the median.' " [Page 1565]

The following day he wrote a letter to the Attorney General which read [page 1456]:

> "Dear Mr. Wishart: Re Mary Doddatto, deceased.
>
> You will recall that I wrote to you on December 9th, requesting a transfer of this inquest from Dr. Noble because I did not feel that he was competent to handle it.

I wrote to you again on December 10th as I intended to take over the inquest under Section 11 of the Act. I did not do so, however, when I received your instructions in your letter of December 12th requesting that Dr. Noble conduct the inquest.

My fears, unfortunately, have turned out to be well founded.

(1) Dr. Noble in his summary to the jury gave them only the recommendation—that highway median strips be 500 to 1,000 feet wide.

This foolish suggestion would wipe out huge areas of Toronto's housing.

(2) The jury blamed the accident on Mr. MacDonald's lack of control or pre-occupation. *There was not one word of evidence to this effect.* This inquest has done a serious injustice to Mr. MacDonald.

I hope you will take steps to correct it.

Yours truly,

Morton Shulman."

The Attorney General did not reply to this letter. Dr. Shulman stated that on February 23, 1967, he had a conversation with the Attorney General in which Mr. Wishart referred to the remark attributed to Mr. Bull and told him that it was quite improper for the Crown Attorney to have said before the inquest, "there was not sufficient evidence to lay a charge, as this prevented him from laying a charge". He also told Dr. Shulman that it was quite wrong of him to have made a statement after the inquest as he did. The Attorney General, according to Dr. Shulman, said:

"I had received your second letter before I replied to the first one but I felt that Dr. Noble should continue with the case regardless. Otherwise I would have been accused of tampering with it."

Dr. Shulman suggests that this evidence indicates that the Attorney General and his Department were actuated by political motives in refusing to let him take over the inquest. On the contrary, the conversation corroborates the information in the letter of the Attorney General to Dr. Shulman, dated December 12, that he wished the inquest to be handled in the usual way by the coroner to whom it had been assigned.

Although Dr. Shulman had made an allegation that there was suppression of evidence relating to an inquest in this case, specifically by the Attorney General, he did not testify as to any evidence that was suppressed. The decision of the Attorney General not to let Dr. Shulman interfere can hardly be described as intervention, but the decision would seem to be proper in any event.

Dr. Shulman knew when giving evidence at the inquiry that there was no evidence to support his suspicion, yet he deliberately used words which would imply that his suspicion was based on fact. When asked if there was any evidence at all that gravel [sand] had anything to do with the accident, he replied:

A. Yes sir, the very *fact* that the police would request sanding that hadn't been done, and I am hoping you will establish that here. [Page 1474 lines 1 to 3] [my italics]

He implied that it was a fact that the police requested sanding. The only evidence was to the contrary. When asked by counsel whether he was establishing this "fact", he replied:

> "I am reporting the *facts*." [Page 1474 line 9] [my italics]

Counsel then put to Dr. Shulman:

> Q. You were reporting your supposition?
>
> A. *Facts*, passed on to me by Mr. McKee, and I know him to be a reliable person of many years contact and I would accept his word. [Page 1474 lines 10 to 13] [my italics]

Dr. Shulman was not reporting facts passed on by Mr. McKee. Dr. Shulman knew after his second conversation with Mr. McKee that what was told to him was nothing but rumour. A rumour passed on by a reliable person is still a rumour and does not become a fact by repetition. Dr. Shulman well knew this as is shown by the following questions:

> Q. Would you tell me why then—why you did not tell Dr. Noble, the Crown Attorney, the Attorney General, anybody else in this world about Mr. McKee's evidence?
>
> A. Because sir, it wasn't evidence. It was a lead and I was unable to trace it down because I couldn't get his contact. [Page 1474 lines 14 to 20]

Later Dr. Shulman referred to the same evidence as "hearsay". [Page 1476 line 18]. Dr. Shulman obviously knew the difference between fact and hearsay. Yet he glibly stated something to be a "fact" when he knew it to be only rumour.

Dr. Shulman in giving testimony stated that there were two reasons why Dr. Noble was not competent to handle this inquest:

> "First was that Mr. MacDonald was involved in it which would mean that there was a good deal of public scrutiny of it and secondly that there was some question your government was responsible for the death." [Page 1469 lines 1-5]

Since Dr. Shulman had previously testified that he didn't hear from Mr. McKee until after he had written the Attorney General, the possibility of Government responsibility could not have been a factor when he wrote the letter.

The evidence indicated that the investigation into the death of Mrs. Doddatto was complete and there was no evidence to suggest any suppression in relation to it. The inquest was held openly and all known witnesses were called. The jury heard the evidence and reached a verdict. What Dr. Shulman alleges to be intervention by the Attorney General was the refusal of the Attorney General to let Dr. Shulman interfere. The inquest was conducted in the usual and normal manner by the coroner to whom the investigation was assigned. For Dr. Shulman to take over an inquest after it had been assigned in the usual way to another coroner would not be normal but unusual. It was Dr. Shulman who attempted to do the unusual and it was Dr. Cotnam and Mr. Wishart who took the position that the inquest should proceed in the ordinary way. How can it be said that the Attorney General was actuated by political motives when he

took no special action against Mr. MacDonald? Had he requested that the inquest be conducted by the Chief Coroner of Metropolitan Toronto who was known to handle major cases, there might have been some criticism of his conduct.

To support allegations that members of the Government or senior officials of the Department of the Attorney General unlawfully and improperly suppressed evidence in relation to an inquest, or unlawfully or improperly interfered with an inquest, requires more than unsubstantiated rumour and conclusions based on suspicion. The facts are simply that Dr. Shulman tried to intervene, was rebuffed, and then tried to suggest that others were acting improperly because they refused his request.

GRAY INVESTIGATION

Pearl Gray was admitted to the Stevenson Memorial Hospital in Alliston for the purpose of having an operation for hemorrhoids. On November 19, 1964, while in the course of performing the operation, Dr. B., who was Pearl Gray's physician, encountered some difficulties and a modified hemorrhoidectomy was completed with some haste. As well, some other work was done in the genital area.

Her post-operative condition deteriorated rapidly and she was transferred to St. Michael's Hospital in Toronto where she was treated for a kidney breakdown, until her death on November 27, 1964. An investigation into Mrs. Gray's death was begun by Dr. E. Cass, a coroner in Toronto, with the assistance of the Alliston police. On December 18, 1964, Dr. Cass wrote Dr. Shulman, enclosing a copy of the police report and stating:

> "Here is a copy of some correspondence I received in the case of Pearl Gray deceased. After reading it over you may form the conclusion that some form of skulduggery was involved in her treatment at Alliston. I sent the original to Dr. Cotnam." [Ex. 154]

In the light of the comments which Dr. Cass made, Dr. Shulman began to inquire and was informed by either the Superintendent of the Stevenson Memorial Hospital or his assistant that there were certain things which appeared very wrong in the situation. [Page 2414 lines 3-14]. On the basis of this information, Dr. Shulman wrote Dr. Cotnam on December 24, 1964, requesting that an inquest be held into the death of Pearl Gray. [Ex. 156]. The Supervising Coroner replied on December 30, 1964, stating that he had already issued instructions to Dr. H. V. Pitcher, a local coroner in Alliston, to hold an inquest. [Ex. 157]. Dr. Pitcher declined to act as he was a member of the staff of the hospital concerned and requested that an outside coroner be assigned to the case. On January 7, 1965, Dr. Cotnam transferred the inquest to Dr. Shannon, another coroner for the County of Simcoe, and forwarded to him the police report. On the same day, Dr. Shulman wrote Dr. Shannon, stating:

> "I have just learned today that you are conducting the above inquest and I wish to make certain requests.
>
> Last year an inquest was held close by in Palmerston under similar unfortunate citcumstances and the presiding coroner did not bring out many facts which were very pertinent to the inquest in relation to the competence of the operating physician. As this case was completely out of my jurisdiction I did not feel that I could take any action.
>
> The Gray case however is different in that Mrs. Gray died in Toronto and subsequent investigation done here has revealed several upsetting facts. I therefore request that at the inquest the following be determined.
>
> 1. Was the operating physician recently suspended from the Alliston hospital for six months?

2. Was this done because of alcoholism and/or drug addiction?
3. If the above is true was the College of Physicians and Surgeons notified? If not why not?
4. Was the R.C.M.P. narcotics squad notified?
5. Before resuming his hospital practice what investigation was done to determine whether the doctor had changed his habits?
6. Had this physician received sufficient training to do this particular operation?" [Page 2416-17 Ex. 158]

Upon receipt of this letter, Dr. Shannon launched an investigation into these allegations and consulted with Dr. Cotnam. Dr. Cotnam thought the allegations were quite serious and deserved to be checked out. [Page 2543 line 10]. Dr. Shannon learned that Dr. B. had been suspended by the College of Physicians and Surgeons for a period of six months and that subsequently his licence was restored. Dr. Shannon believed that when the College restores a licence it is sure that things have been corrected. In addition, other members of the hospital staff had assured him that no consumption of alcohol was involved at this time and that Dr. B. had been behaving himself for the past year and one-half since his licence had been restored. [Page 2466 line 25 to page 2467 line 4]

The result of Dr. Shannon's investigation was that Dr. B. was not under the influence of either drugs or alcohol at any relevant time, and consequently he was satisfied that the questions suggested by Dr. Shulman were improper and had nothing to do with the inquest. [Page 2433 lines 20-23 and page 2467 lines 3-4]. Dr. Shannon's decision was concurred with by Dr. Cotnam who also made some inquiries into Dr. Shulman's allegations. From the discussions which Dr. Cotnam had with Dr. Pitcher, Dr. McFarland, who was the anaesthetist in attendance during the Pearl Gray operation, and John Bowerman, a solicitor for the hospital, he discovered that Dr. B. had had some trouble in the past, but his hospital privileges had been restored and at the time of the operation he was not impaired in any manner. As well, Dr. B. had successfully completed a Dilation and Curettage and a vaginal hysterectomy on the morning prior to his operating on Pearl Gray. Dr. Cotnam believed that if Dr. B. was qualified to perform such surgery, he was qualified to operate on Pearl Gray. [Pages 2526, 2527, 2528]

At the inquiry, Dr. Shulman admitted that he had no facts to contradict what Dr. Shannon said regarding the doctor's condition. [Page 2511 lines 14-16]

Since there was no evidence to suggest that the attending physician was under the influence of alcohol or drugs at the time of the operation, Dr. Shulman's questions as to his prior history were irrelevant, and the coroner's refusal to put such questions to the jury was not an unlawful or improper suppression of evidence. Indeed it would have been most unfair for Dr. Shannon to have done so.

On January 20, 1965, the inquest was held. Evidence was given by the attending physician, by the anaesthetist, by the operating room supervisor, by the supervisor of the surgical ward, by a consulting surgeon, by a specialist in

urology, by a specialist in internal medicine and by a specialist in pathology. The jury found that:

> "death was caused by peritonitis, major contributing factor being non-functioning kidney. We do not find that any negligence had been proven. We recommend that the press should refrain from passing an opinion." [Page 2440 line 27 to page 2441 line 3]

This last recommendation was apparently voluntary as Dr. Shannon did not instruct the jury in this regard in one way or the other. [Page 2441 lines 4-11]

On January 21, 1965, Dr. Shulman wrote to the Attorney General, stating:

"The inquest was held yesterday into the death of Mrs. Pearl Gray in Alliston and for the following three reasons I submit that it was improperly conducted and should be quashed.

1. The jury contained patients of the doctor whose conduct was under question. Comments of the foreman, a patient of this doctor, explain the very strange verdict.
2. There was no identification evidence presented as to whether the body autopsied actually was that of Mrs. Gray.
3. I enclose a copy of a letter sent two weeks ago to the presiding coroner. The questions which I requested be answered at the inquest were not asked and the jury cannot bring in a proper verdict when it does not know all the facts.

For the preceding reasons I request that a new inquest be held." [Page 2418 Ex. 159]

In a letter to Dr. Shulman dated February 10, 1965, the Attorney General replied, stating:

> "There are certain fundamental principles of our society that are fundamental not only to the administration of justice but also to the civil rights and liberties of all the citizens of this Province. It is fundamental that any person who is accused of misconduct either of a civil or of a criminal nature must be brought before a court of competent jurisdiction in order that he might not only have full knowledge of the charge but also that he may be given the opportunity to defend the charge, to cross-examine witnesses, to call witnesses, and to submit argument to the court. In the course of any such proceedings the rules of evidence are adhered to to ensure that there are no unjustifiable excursions—into areas that are not relevant to the charge. In your letter of January 7th to Dr. Frank Shannon of Barrie, you took it upon yourself to suggest that certain questions be asked and that certain determinations be made which, in my opinion, had no relevance whatsoever to the purpose of the inquest. The questions were not only irrelevant in that context but they were of a nature that would not have been admitted in any court of law. Questions relating to the past conduct of the attending physician with additional questions suggesting misconduct on a prior occasion because of alcoholism or drug addiction could completely ruin the reputation of the physician in this forum where he has no legal rights whatsoever to defend himself against these innuendos and their possible implications. This is even more unreasonable when I am advised that the evidence at the inquest affirmatively established that the attending doctor appeared to be completely normal at the time of the operation and there was absolutely no suggestion that he was impaired in any way.

I am not aware of any circumstances which would justify the type of question you suggested to Dr. Shannon, and if there is any justification, would you let me have it." [Ex. 59 + Page 2422-2423]

On February 16, 1965, Dr. Shulman wrote to the Attorney General, stating:

"The questions which I requested to be asked at the inquest were to establish that if the medical authorities in Alliston had done their duty and notified the College of Physicians and Surgeons, disciplinary action would have been taken and this operation would not have taken place and the patient would be alive today. This could be most important in preventing further operative deaths. The most important point was of course that this was a biased, improper jury, headed by a foreman currently a patient of the doctor involved." [Page 2425]

Before dealing with this correspondence I should point out that Dr. Shulman alleged that in this case there was an unlawful or improper suppression of an inquest. His allegation was directed against the Attorney General and the Supervising Coroner, and the basis of his allegation would seem to be that they refused to order a second inquest when he requested one.

The Attorney General in his letter to Dr. Shulman pointed out that questions relating to the past conduct of the attending physician were irrelevant and inadmissible, and further that the proper place to try issues of criminal or civil responsibility was in the courts. He then inquired as to whether Dr. Shulman had any evidence to indicate that the physician was not normal at the time of the operation. In answering the Attorney General's letter, Dr. Shulman gave no particulars of any such circumstances. He suggested that the medical authorities in Alliston were derelict in their duty in not notifying the College of Physicians and Surgeons so that disciplinary action could have been taken, yet gave no evidence of any misconduct that should have been reported. His statement that "this operation would not have taken place and the patient would be alive today" is, under these circumstances, a non sequitur.

The last sentence of his letter said:

"The most important point was of course that this was a biased, improper jury, headed by a foreman currently a patient of the doctor involved."

With respect to Dr. Shulman's complaint about the composition of the jury, Dr. Shannon testified that he did not learn that some of the jurors had been patients of Dr. B. until immediately before the inquest began and that the Chief of Police of Alliston had been responsible for assembling the jury. After the jury had been convened, Dr. Shannon instructed its members as to their duty and as far as he was concerned from the inquiries he had made after the inquest, he had no reason to believe that any of the men had failed to carry out his oath. He testified as to the results of his inquiries as follows:

Q. What are the facts then so far as these people are concerned? What relation did they have to this doctor?

A. Mr. Franks . . .

Q. Yes?

A. . . . the foreman, used to be a patient of the doctor concerned, but he had not been a family physician; nor had none of his family seen him in the last five years.

Q. That is, prior to the inquest?

A. Prior to the inquest.
He had changed his family physician.

Q. So he really was not then a present patient of the doctor?

A. That is correct.

Q. All right. What about the others you were able to find?

A. Mr. Elmer Gilroy . . .

Q. Yes?

A. He had not been attended personally in the last five years.

Q. So the situation with that one was he had been a patient of the doctor five years prior, relating to the time of the inquest?

A. Yes.

Q. He had not been a patient for some five years?

A. That is right. His wife and family had been.

Q. But not himself?

A. That is right. He knew when he served on the jury that he was under oath and he doesn't feel that his personal feelings would have had anything to do with his decision if it had gone against the doctor.

Q. That is what you would expect of an honest juror?

A. Yes, that is right. Mr. Bendell, he has never been attended by the doctor.

Q. He is one of these jurors you are talking about?

A. He considers him to be the family physician, but he himself has never attended.

Q. He was the family physician but not the physician to the juror himself?

A. If the doctor had been proven at fault he feels he would have done exactly as he did.

Q. The other one, of course, you were not able to contact?

A. Mr. Armstrong. His family physician. Mr. Armstrong, Junior. He wanted to be certain of the integrity of his physician. If his physician did not have integrity that he should have had then he wanted to know about it and therefore he went into the inquest with his eyes open.

Q. In other words, he was determined to find out whether this was a doctor of integrity or not. I assume if he was not he would have been prepared to find so?

A. That is correct. [Page 2438 line 11 to page 2440 line 12]

Dr. Shannon testified that in a small town of less than three thousand people, probably one hundred per cent of the people would have been to Dr. B. at some time. [Page 2437 line 4-11]

Dr. Cotnam stated that he did not learn of the composition of the jury until after the inquest and although he felt it was a little out of the ordinary to have the jury weighted with Dr. B.'s former patients, he did not believe this fact would disqualify a man for jury duty as there was nothing in the Coroners Act against it. [Page 2553 lines 5-11]. There is no doubt that the composition of the jury left something to be desired, but the evidence indicates that the jury was not "biased", was not "improper", and that the foreman was not "currently a patient of the doctor involved". Dr. Shulman's statement of the facts was not accurate.

In his letter to the Attorney General Dr. Shulman stated that there was no identification evidence presented as to whether the body autopsied actually was that of Mrs. Gray. An examination of the inquest evidence that was filed as Exhibit 165 indicates that Dr. Jaffe, the pathologist, testified that he conducted a post-mortem examination on the body of Pearl Gray, which was identified to him by Dr. George Duncan, an employee of the City Morgue, on November 27. He then went on to describe the body and to give his opinion based on his findings. No question was raised at the inquest as to identity.

Dr. Shulman's specific allegations against Dr. Cotnam at the inquiry were, first, that Dr. Cotnam was aware that the jury consisted largely, if not entirely, of patients of the doctor whose conduct was under question, and second, that he should have ordered a new inquest after Dr. Shulman requested one.

Dealing with the first allegation, Dr. Cotnam testified that he did not learn the composition of the jury until after the inquest, but knew of no regulation disqualifying a juror merely because he had been treated at some time in the past by a physician who might be involved. Dr. Shulman produced no evidence to suggest otherwise. He had no evidence to suggest that any jury deliberately came to a wrong verdict to favour the doctor. [Page 2506 lines 23-27]

Dr. Shulman testified that his allegations against Mr. Wishart and Dr. Cotnam were premised on the fact that something was not explored that should have been. [Page 2513 line 13]. I have already referred to the evidence of Dr. Shannon and Dr. Cotnam as to the investigations conducted by them.

Although Dr. Cotnam never personally made inquiries at the College of Physicians and Surgeons, his executive assistant, Mr. Hills, wrote to Dr. Shannon on January 25, 1965, stating:

> "May I suggest the photostat copy be forwarded to Dr. Dawson of the College of Physicians and Surgeons for his comments regarding the questions that Dr. Shulman suggests be asked. Surely this is character assassination at its worst. Many thanks for showing us the letter." [Page 2435 + Ex. 162]

Dr. Shannon did inquire of the College. His evidence on this point was as follows:

> "The man had been suspended by the College of Physicians and Surgeons for a period of six months but he had been restored. When the College restores someone's licence, they are very sure things have been corrected." [Page 2466 lines 25-29]

Consequently it seems to me that Dr. Shulman's allegation that something was not explored that should have been is not supported by the evidence. If as he says he premised his allegation on this "fact", then his premise was false and the allegation untrue. Further, Dr. Shannon's refusal to put improper and irrelevant questions to the jury was not a ground for ordering a second inquest.

Dr. Shulman suggested that the jury's verdict was wrong because it was inconsistent with the evidence of Dr. Jaffe.

Dr. Shannon testified that there was a difference of medical opinion and that the jury accepted the evidence of three other doctors rather than the evidence of Dr. Jaffe. [Page 2443 line 16]. In addition, Dr. Shannon stated that he agreed with the jury's finding that there was no negligence, but not with their finding as to the cause of death. [Page 2441 lines 23 and 24]. He believed that the perforated rectum may have been caused by a fleet enema administered by the nurse the night before. In any event, this again is a matter of opinion.

It is not the function of this inquiry to determine whether the verdict of the jury was the correct one. I have no reason to believe that the jurors did not honestly arrive at their conclusions. The fact that Dr. Shulman did not agree with the verdict was not a reason for ordering a new inquest. I have already disposed of the other reasons put forward by Dr. Shulman.

Dr. Shannon in giving evidence made it quite clear that he was not directed by anyone from the Supervising Coroner's office or any senior civil servant to suppress the inquest or any of the evidence or to conduct himself in any way other than his own conscience directed. [Page 2443 line 30 to page 2444 line 6].

I find there was no unlawful or improper suppression of an inquest or evidence in relation to an inquest by any member of the government or senior official of the Attorney General's Department in this matter.

MOORE INVESTIGATION

The terms of reference were broadened so that I might inquire into the circumstances surrounding the death of Barbara Moore. This case was referred to by Dr. Shulman as one in which there had been an unlawful or improper suppression of evidence in relation to or of an inquest. [Page 592 lines 19-26 and page 596 lines 1-5]. The allegation is against the Attorney General and Dr. Cotnam. The matter was referred to earlier under the chapter dealing with files and was relied on by Dr. Shulman as an instance in which a document mysteriously disappeared.

Barbara Moore, a three-year-old child, died in Pembroke General Hospital, On October 10, 1961, a few hours after a routine tonsilectomy and adenoidectomy. Dr. H. B. Cotnam, a local coroner at Pembroke, was appointed to conduct an investigation. He decided that an inquest was not necessary.

Three years later, Dr. Shulman was searching through closed files in the cellar of the Coroners Building. The files were those of Dr. Smirle Lawson, a former Supervising Coroner for Ontario, who died some years ago. Dr. Shulman came across a letter from Dr. Cotnam to Dr. Lawson, and the carbon copy of Dr. Lawson's reply. The letters read:

"Dear Dr. Lawson:

Re: Barbara Moore—age 3 yrs.—deceased.

I have a problem death right now—a 3 year old girl who died 2 hours after T & A of Cardiac failure due to a huge pneumoperitoneum from multiple ruptures in stomach from too vigorous administration of oxygen in Recovery Room by a graduate nurse—first day in said Recovery Room position.

Should we hold an inquest in all anaesthetic and surgical deaths occurring in Operating-Rooms or deaths from complications of surgery as in this case? Should an inquest be held routinely in these cases or judge each one on its own merits and what should I do in this particular case now? Autopsy showed 3 separate tears on the lesser curvature of the stomach where it ripped from extreme over-distension with air and O_2. The parents appeared quite understanding to the attending Physician at first (death was Oct. 10th, 1961) but now I am hearing rumbles of discontent and the family have been talking to various people including newspaper reporters etc.

Would you drop me a line and advise me in this case? Should we try to keep our professional colleagues and nurses and hospitals out of the unfavorable limelight of inquests and newspaper columns as far as possible in co-operation with the Crown-Attorney or should all these cases be given the publicity—unfavorable or otherwise—that goes with holding investigations and inquests? This is my problem at present and I am sure it is one which

every Coroner must face frequently—so I would certainly appreciate any directives or advice you can give me at this time regarding this case and similar ones in future?

I thank you for your help and advice.

I remain,

Yours very truly,

H. B. Cotnam, M.D.
Coroner
County of Renfrew."

"Dear Doctor Cotnam—

RE: Barbara Moore, Aged 3 Years (D).

We, in Toronto, do not hold inquests in all deaths due to Anaesthetic or Surgical deaths, as they are usually accidental.

My advice to you would be to consult with your local Crown Attorney, and if he thinks an inquest should be held, then hold an inquest.

In my opinion, I do not think an inquest is necessary.

Thanks for writing me about this case, and also for your good work in Renfrew County, and with kindest regards to you.

Yours sincerely,

Supervising Coroner For Ontario."

When Dr. Shulman found these letters Dr. Cotnam held the position of Supervising Coroner for Ontario and Dr. Shulman was Chief Coroner for Metropolitan Toronto. It is obvious from the evidence that by 1964 there was ill feeling between these two men, which may in part explain their conduct towards each other. On August 24, 1964, Dr. Shulman telephoned Mr. John Mulcahy, the Crown Attorney at Pembroke, and inquired whether an inquest had been held in this matter. Mr. Mulcahy said he would look up his files and call him back. He did so a few days later and advised Dr. Shulman that no inquest had been held. Dr. Shulman said that Mr. Mulcahy told him that no inquest was held on the instructions of Drs. Cotnam and Lawson. Dr. Shulman then wrote a letter to Mr. Mulcahy on October 9, 1964, requesting a copy of the investigation report required to be filed under Section 12 of the Coroners Act. Mr. Mulcahy replied by letter on October 13, 1964:

"I am unable to locate my copy of the Coroner's Investigation Report with reference to the above deceased and therefore I am unable to forward the same to you.

In view of the fact that this death occurred in the County of Renfrew and at that time Dr. H. B. Cotnam was the investigating coroner, I suggest that any information pertaining to this occurrence should be obtained from him."

When called as a witness, Mr. Mulcahy stated that he had been Crown Attorney for the County of Renfrew since January 1, 1961. His office was in Pembroke. On October 13, 1961, he received a telephone call from Dr. Cotnam, a local coroner, advising him that Barbara Moore had died on October 10. At that time Dr. Cotnam supplied him with particulars and Mr. Mulcahy

prepared a memorandum for his file. Mr. Mulcahy's memorandum dated October 13, 1961, reads:

"Re Barbara Moore, 3 years.

Barbara Moore, an infant approximately three years of age, on Tuesday, October 10th was operated on in the Pembroke General Hospital for tonsilectomy and was operated on by Dr. McCluskey and the anaesthetic given by Dr. Foohey.

The operation appeared to be a normal one and the child was removed to the recovery room. Mrs. Clare Schouten was in charge of the recovery room and at a certain point, due to the change in colour of the child, oxygen was administered. The child then regained consciousness and then was transferred to the ward.

Later in the morning on making rounds, Dr. Foohey found that the child's abdomen was distended to a great degree and they immediately rushed the child to the operating room where they removed gas which was in the abdomen but outside the stomach. The child later died and they immediately did a post-mortem examination and found that there was a hole in the wall of the stomach and that the oxygen had escaped through the stomach into the abdominal cavity and had, in a sense, suffocated the child."

Dr. Cotnam reported the case to him by telephone, which was the custom with all coroners in that county. Later the same day Dr. Cotnam called again and they discussed whether or not an inquest was necessary. At that time Dr. Cotnam stated that he would get in touch with Dr. Lawson, the Chief Coroner for Toronto, and secure his opinion. Mr. Mulcahy agreed with this suggestion.

Approximately three weeks later Dr. Cotnam telephoned Mr. Mulcahy, told him that he had a reply from Dr. Lawson and that in Dr. Lawson's opinion an inquest was not necessary. As far as Mr. Mulcahy was concerned as Crown Attorney, the matter was then closed. In due course he received a carbon copy of the autopsy protocol from the pathologist's office. This was filed with the post-mortem reports.

Approximately three years later (he thought the date was August 25, 1964) he received a phone call from Dr. Shulman, asking if there had been an inquest into the death of Barbara Moore. Mr. Mulcahy told him that he would check his records and call him back. He did so and advised Dr. Shulman that there had been no inquest. Mr. Mulcahy denied saying to Dr. Shulman that "no inquest was held on the instructions of Drs. Cotnam and Lawson".

Subsequently Mr. Mulcahy received a letter dated October 9, 1964, from Dr. Shulman requesting him to forward a copy of the coroner's investigation report. Mr. Mulcahy replied by letter that he could not locate his copy of the report. He stated that since that time he had come to the conclusion that no report was made. In retrospect he stated that when he and Dr. Cotnam first discussed this matter no decision was made whether an inquest would be held. When Dr. Cotnam heard from Dr. Lawson he reported to the Crown Attorney orally. He did not receive any material in writing relating to this matter from Dr. Cotnam. Shortly after, Dr. Cotnam left Pembroke to become Supervising Coroner for Ontario

Mr. Mulcahy emphatically denied that he ever destroyed any document relating to the Barbara Moore case or caused it to mysteriously disappear.

While giving evidence earlier about another matter, Dr. Shulman said [page 583 line 29 to page 584 line 1]:

> "I think you will find the files in the Barbara Moore case have just disappeared from the hospital."

This statement gained wide publicity in the press. If the statement were true it would suggest that evidence was being suppressed improperly.

Dr. G. L. Hermitte was called by Dr. Shulman.

It was Dr. Hermitte who telephoned Dr. Shulman and told him that he had been informed that the X-ray file was missing. Later Dr. Hermitte made inquiries and learned that this information was incorrect. He found that the file had merely been removed from the X-ray department to the medical records department for administrative purposes, and then returned.

Sister Sainte Hedwig of the Pembroke General Hospital was called as a witness and produced the hospital file relating to the Barbara Moore case. It had never "disappeared from the hospital". The rumour spread by Dr. Shulman was false.

The Hospital file did not contain an X-ray report. Sister Sainte Hedwig said it was her belief that the radiologist had been present in the operating room with the attending physician and reviewed the plates at the time. After the death of the patient the films may have been put into the file without a report in writing having been made. This occasionally happens.

Dr. K. Matzinger was the radiologist at Pembroke General Hospital in 1961 who examined the X-rays taken of Barbara Moore before her death. He stated that it was an emergency, so he reviewed the plates with the treating surgeon in the operating room and decided that there was a perforation of the stomach. To confirm this they decided to inject a dye through a gastric tube into the stomach. This was done but the child went into shock and expired. He has no recollection that he ever at any time made a written report of his opinion in this case. It occasionally happens that when Dr. Matzinger gives an oral report he does not give a written one. This is usually by oversight, as the films are filed or removed elsewhere. Following the child's death a post-mortem was performed and the pathologist reported that the child had a ruptured stomach.

Dr. Shulman did not get in touch with Dr. Cotnam as suggested by Mr. Mulcahy. Instead he wrote a letter to the Attorney General dated October 13, 1964, as follows:

> "Dear Mr. Wishart:
>
> Last spring you were kind enough to suggest that in case of serious difficulties I come to see you to discuss the matter.

A serious problem has now arisen and I would very much appreciate your giving me a few minutes to explain it to you. The matter is quite important and I would be pleased to come to your office at any time which is convenient to you.

Yours truly,

Morton Shulman, M.D.
Chief Coroner."

Mr. Frank Wilson, the Assistant Deputy Attorney General, requested a report from Dr. Cotnam and a written report was prepared. Mr. Wilson discussed the matter with Dr. Shulman. He understood that Dr. Shulman at first intended to use the letters because of a remark Dr. Cotnam had made about Dr. Shulman; but Dr. Shulman no longer wished to pursue the matter, since an inquest would serve no useful purpose. Having regard to this conversation, Mr. Wilson thought the matter was dead.

On January 13, 1965, Dr. Shulman wrote a follow-up to his first letter to the Attorney General. The portion relating to the Barbara Moore case reads as follows:

"Three months ago today I wrote you explaining that a serious problem had arisen and requesting an interview. I am sorry to note that I have neither received an interview nor a reply to my letter.

I did see your deputy's assistant in late October and showed him a copy of the relevant facts. He informed me that Mr. Mulcahy had already come down from Pembroke to give you the information. It was my feeling an inquest should not be held at such a late date as it would cause renewed and unnecessary anguish for the parents. I hope that there is a less painful method of handling this problem."

The letter of the Attorney General in reply, dated January 20, 1965, so far as it deals with the Barbara Moore matter, reads:

"Dear Dr. Shulman:

Re: 1. Barbara Moore—deceased.

This will acknowledge receipt of your letter of January 13th which I understand you delivered to the Assistant Deputy by hand.

Following your previous letter of some weeks ago, an attempt was made to reach you. Although I did not see you at that time, I was informed that you had discussed problems with Mr. Wilson of my staff and I understood that the matters were resolved.

I had no knowledge that you were still seeking an interview with me. Please be assured that I would be glad to arrange an appointment at any time.

With respect to the matter of the death of Barbara Moore, having reviewed the material, I agree with you that an inquest should not be held at this time, more than three years since the date of death, since as you state, it would cause renewed and unnecessary anguish for the parents.

I note from my file that the matter was again very thoroughly reviewed by Dr. H. B. Cotnam as Supervising Coroner in October of last year and he reached the conclusion that no useful purpose would be served by an inquest at this time.

I note further that a very thorough investigation was made at the time of the death, including a complete autopsy by Dr. Bobra, the Regional Pathologist in Pembroke at the time. A thorough history was also obtained from attending physicians, the Sister in charge of the operating room, the nurses in charge of the recovery room and other hospital personnel. The matter was discussed with the Crown Attorney, who was given full details, and was referred to Dr. Smirle Lawson, the Supervising Coroner at that time. In his opinion an inquest was not necessary unless the Crown Attorney should so decide. I have not seen Mr. Mulcahy regarding this matter, but as he did not request an inquest, although aware of the facts, it is apparent he considered no inquest necessary. It would appear that the parents of the deceased child were fully informed and the facts as to cause of death were set out in the medical certificate of death.

If the same circumstances were to occur today, no doubt an inquest would be ordered, but I agree with you an inquest should not now be held.

You mention another method of dealing with the matter. I should be glad to have your views."

No doubt the Attorney General, when he wrote the letter of January 20 to Dr. Shulman, was passing on information that had been supplied to him by his staff, but as will be seen later there is some conflict as to whether Mr. and Mrs. Moore were "fully" informed.

Dr. Shulman's reply of January 21, 1965, to the Attorney General, reads:

"Re: Barbara Moore. The important issue at the present time is the fact that a senior member of your department lied to the public, in March of '64, in such a way as to suggest that in fact it was myself that was telling an untruth. It is not for me to suggest what level of honesty you should expect from your own staff—however if it is not your intention to take any disciplinary action, I feel that I must at least clear the public slur on my own truthfulness."

The reference to "disciplinary action" in Dr. Shulman's letter indicates that he was not interested as much in justification as in revenge. I am not interested particularly in Dr. Shulman's motives; I am interested in whether there was any unlawful or improper suppression of an inquest or evidence in relation to an inquest. Witnesses were called to testify as to the circumstances surrounding the death.

Dr. Lawrence McCluskey is Chief of Surgery at the Pembroke General Hospital, as he was in October of 1961. Barbara Moore, a patient of his, aged three, was admitted to the hospital on or about October 9, 1961, for a tonsilectomy. Routine tests and examinations were performed both by him and by Dr. J. O. Foohey, the anaesthetist. The anaesthesia was normal, vinethene and ether by open drop. There was no other gas administered to this patient or any other material, either under pressure or otherwise during the operation. The tonsilectomy and adenoidectomy were uneventful. The condition of the child at that time was normal and she was transported to the post-operative recovery room. The post-operative recovery report made by the nurse in charge of the recovery room indicates that the child was received from the operating room in good condition. Dr. McCluskey then returned to the doctors' room and carried on with other work.

While there he received a call to attend at the post-operative recovery room and he did so immediately. When he arrived he saw that the child was cyanosed or turning blue. He noticed that the child was receiving some oxygen. He had not given specific instructions regarding this but no specific instructions were necessary because the administration of oxygen under these circumstances was routine. He looked for obstruction and found that the tongue had fallen back into the throat obstructing the child's airway. He pulled the tongue forward and inserted a small rubber tube to prevent recurrence of this condition. After he removed the obstruction and inserted the tube the child's condition immediately improved and her colour returned to normal. He checked for bleeding in the region where the tonsils and adenoids had been removed but found none. He checked for complications and found none. Dr. McCluskey then left the post-operative recovery room.

Later Dr. McCluskey was summoned to the Children's Ward of the hospital to see Barbara Moore. He found the child restless, irritable and markedly distended about the abdomen. She was mottled and breathing was rapid. He decided that the child had some inter-abdominal complications involving the stomach. At that time he thought the condition was acute gastric dilation, a not uncommon condition seen after operations. An attempt was made to treat her with a Levine tube to suck off the excess gas and fluids but the results were poor. The child was then taken to the X-ray room and some films were taken of the chest and abdomen. The child was then taken to the operating room to proceed with treatment.

Dr. Foohey was present at this time and Dr. Matzinger was summoned. Dr. McCluskey was successful in getting the Levine tube into the child's stomach but this did not help the condition very much. Dr. Matzinger, the radiologist, then arrived in the operating room with the films and they were examined by the three doctors. It was Dr. Matzinger's opinion that air had somehow escaped into the peritoneal cavity. They decided that this had to have occurred because of a rupture of an organ of the gastro-intestinal tract. They did not know which organ but decided that this condition had to be treated by the insertion of needles through the abdominal wall in order to allow the deflation of this pressure condition which was interfering with respiration. Needles were inserted and quantities of air were let out. The child improved somewhat but the improvement was not satisfactory.

Further X-rays were taken and while they were being developed they continued letting air out of the child's abdomen. Dr. McCluskey noted that the child's pupils were markedly dilated which meant that the child was not getting enough oxygen to her brain because the lungs were being compressed by the distended abdomen. It was an emergency situation. They decided an attempt should be made to locate the rupture by feeding a radio-opaque dye through the tube which had been inserted into the stomach, to see whether the dye would leak out and show where the hole was. The dye Hypaque was administered. The child's condition continued to deteriorate and her heart stopped. Dr. McCluskey opened the child's chest and massaged her heart in an attempt to resuscitate her circulation but this was unsuccessful.

After the child died, Dr. McCluskey arranged for a coroner to be notified and then talked to the family, Mr. and Mrs. Moore. Dr. McCluskey stated that he told them exactly what had happened as he knew it then. At that time he had formed no conclusion as to whether there had been too vigorous administration of oxygen. He still thought that what he had been treating was an acute gastric dilation. He told Mrs. Moore that after he had seen the autopsy findings he would contact her again to let her know if he found anything different.

The autopsy was held by Dr. Bobra and his findings, as entered on the autopsy report, were that death was due to acute stomach dilation; rupture of stomach; pneumoperitoneum; congestion of abdominal vein; shock; cardiac arrest. After the autopsy, Dr. McCluskey drove to Petawawa to the home of the Moores and made this information known to them, which confirmed what he had previously told them. Dr. McCluskey could not recall whether or not he told Mrs. Moore anything about oxygen.

Following the death of the child and before the autopsy, Dr. McCluskey received a telephone call from Dr. Cotnam who requested particulars. Dr. McCluskey said that when Dr. Cotnam interviewed him he gave him all the facts he knew. Subsequently Dr. Cotnam contacted him regarding his conversation with the Moores and then told him that he would call them and let them know what he knew about the case as coroner.

Dr. Cotnam stated that it was his recollection that he had called Mrs. Moore and told her the result of his investigation, but he was not positive as to this.

Mrs. Moore denied receiving a telephone call from Dr. Cotnam. She said that Dr. McCluskey saw her in the doctors' lounge on the day of the operation and told her that, after a normal tonsil operation, complications had arisen and the child's stomach had become distended and they had tried to treat it. Later he thought that the stomach was ruptured and when they were treating this complication the heart stopped. He told her that they opened the chest and massaged the heart but that failed also. She did not remember any discussion about oxygen.

After the post-mortem the doctor travelled out to their home in Petawawa and stated that the post-mortem confirmed his previous views in the matter. Mr. Moore did not recall the first discussion with Dr. McCluskey but did recall the second at their home. He had no recollection of anything being said about oxygen. Both parents were understandably upset at the time and it is over five years since the unfortunate incident occurred, but considering their evidence along with that of Dr. McCluskey, I am satisfied that nothing was said about the part oxygen may have played in the death of the girl. Since Dr. McCluskey thought the child was suffering from actute gastric dilation and resulting complications, there is no reason why he would tell them otherwise.

It was Dr. Cotnam who reached the conclusion, after his investigation, that there had been a too-vigorous application of oxygen in the recovery room. Dr. Cotnam may have been under the impression that the parents were fully

informed as to the cause of death, because of his conversation with Dr. McCluskey. Whether he intended to call them or not, I do not know, but I am satisfied he did not.

Dr. Cotnam did not discuss with Dr. McCluskey whether or not he would recommend that an inquest be held. Certainly Dr. McCluskey did not ask Dr. Cotnam not to hold one.

Dr. McCluskey was referred to the first paragraph in Dr. Cotnam's letter to Dr. Lawson, in which he stated:

> "I have a problem death right now—a 3 year old girl who died 2 hours after T & A of Cardiac failure due to a huge pneumoperitoneum from multiple ruptures in stomach from too vigorous administration of oxygen in Recovery Room by a graduate nurse—first day in said Recovery Room position."

Dr. McCluskey agreed with the first portion of this paragraph but was not prepared to say that the death occurred "from too vigorous administration of oxygen in recovery room". Neither was he prepared to agree with the subsequent words "by a graduate nurse—first day in said recovery room" since he was not aware whether it was in fact her first day in the recovery room. He was aware that she had a special certificate in this type of work.

Dr. Shulman suggested that the accident may not have occurred in the recovery room at all, but in the operating room. Dr. McCluskey stated emphatically that no oxygen was used at any time in the operating room while treating this patient, and that Dr. Shulman's theory was not consistent with the facts. Dr. McCluskey agreed that a ruptured stomach following a tonsilectomy is very uncommon and that the circumstances in which this death occurred following what was apparently a normal and successful tonsilectomy were unusual.

Dr. H. B. Cotnam stated in evidence that on October 10, 1961, when he was a local coroner in Pembroke, he received a call from the hospital that a baby by the name of Moore had died. He proceeded to the General Hospital, saw the body, and then conducted a routine investigation to ascertain all the facts which had led to the death of this child. He talked to Dr. McCluskey, the surgeon, Dr. Foohey, the anaesthetist, Dr. Matzinger, the radiologist, the supervisor in charge of the operating room, the nurses in the operating room, and the girl in charge of the recovery room. Subsequently he talked to Dr. Bobra, the pathologist. No one suggested to him that an inquest should not be held.

He looked at the X-rays and discussed them with Dr. Matzinger. It was apparent from the films that there had been multiple ruptures of the stomach. After speaking to the various persons involved, Dr. Cotnam came to the conclusion that the stomach was ruptured following the surgery and that it could not have happened in the operating room because no oxygen was used there. Oxygen was used in the recovery room. He concluded that the accident had happened in the post-operative recovery room.

After conducting his investigation he put down the conclusions he had reached on the death certificate. A copy of the statement of death and certificate of death taken from the hospital file was filed as an exhibit. The medical certificate portion, signed by Dr. Cotnam, gave as the cause of death "cardiac arrest due to obstruction inferior vena cava due to tremendous pneumoperitoneum—due to multiple ruptures of stomach—due to resuscitation with oxygen in recovery room following T and A".

Dr. Cotnam stated that although as a local coroner he investigated twenty or thirty deaths a year, he had never investigated a death like this before and the case was somewhat of a dilemma to him. He consulted with some of his colleagues in town. They had never heard of a similar death. He then spoke to the Crown Attorney and acquainted him with the problem.

In October of 1961 a coroner had full authority to order an inquest without consultation with the Crown Attorney, but Dr. Cotnam was not aware of the recent amendment to the Act which made the consent of the Crown Attorney or Attorney General unnecessary. He thought that he was obliged to consult with the Crown Attorney and he did so. In certain cases inquests are mandatory under the Coroners Act. This death did not fall within that class. Other cases are assessed by the local coroner who must decide whether an inquest is necessary. This death fell in this latter category. At that time it was not customary to hold as many inquests as are held today, not only with respect to medical hospital deaths but with respect to any type of death.

After receiving Dr. Lawson's reply containing his opinion, Dr. Cotnam spoke to the Crown Attorney on the telephone and acquainted him with the opinion of Dr. Lawson. Mr. Mulcahy told him that in view of this opinion an inquest would not be held.

Section 12(1) of The Coroners Act requires that:

> "Where the coroner determines that an inquest is unnecessary, he shall issue his warrant to bury the body, and shall forthwith transmit to the Crown Attorney a signed statement setting forth briefly the result of the investigation and the grounds on which the warrant has been issued, and shall also forthwith transmit to the division registrar a notice of the death in the form prescribed by The Vital Statistics Act."

Dr. Cotnam did not comply with this section. He reported to the Crown Attorney orally, but not in writing.

Dr. Cotnam admitted that this death was unusual. He agreed that if the circumstances in the Barbara Moore case were to arise today he would order an inquest. When asked what change there had been in the law since 1961, if any, that would justify a change in decision, Dr. Cotnam stated that it was not so much a change in the law as a change in the whole coroners' system between 1961 and now. Today there are more inquests and more constructive and useful recommendations. Dr. Cotnam agreed that in his later experience as Supervising Coroner he has put considerable emphasis on the importance of recommendations and on the importance of preventing similar deaths. He sent out a circular to this effect in April of 1964 to all coroners. On cross-examination he

was asked whether he did not agree that if a death was unusual there should be an inquest and he stated that the coroner must try to determine the circumstances that exist in each particular case and whether it would serve a useful purpose to hold an inquest. One useful purpose might be to prevent any repetition of the same misfortune. Unfavourable publicity that could serve no useful purpose might also be a factor for consideration. He stated that every operating-room death does not necessarily require an inquest.

Counsel for Dr. Shulman suggested that Section 7(1) was the key section. The section provides:

> Every person who has reason to believe that a deceased person died,
>
> (a) as a result of,
> (*i*) violence,
> (*ii*) misadventure,
> (*iii*) negligence,
> (*iv*) misconduct, or
> (*v*) malpractice;
>
> (b) by unfair means;
>
> (c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
>
> (d) suddenly and unexpectedly;
>
> (e) from disease or sickness for which he was not treated by a legally qualified medical practitioner;
>
> (f) from any cause other than disease; or
>
> (g) under such circumstances as may require investigation,
>
> shall immediately notify a coroner of the facts and circumstances relating to the death. [1960-61, c.12, s.3]

Dr. Cotnam was referred to an address by Mr. Eric H. Silk, Q.C., to the regional meetings of coroners in 1959-60, entitled "Advice to Coroners", wherein Mr. Silk said:

> "I am of the view that where as a result of his investigation the Coroner finds any of the elements enumerated in Section 7 present, he should hold an inquest. To express it another way, where there is any indication that the death was not a natural death—a death from natural causes—he should hold an inquest."

Dr. Cotnam agreed with most of this statement. He has expressed similar views in lectures printed and distributed by him to coroners. One such memo read:

> "As a result of this investigation a coroner must decide whether death is from natural causes or otherwise. When there is an indication that the death is not from natural causes he should hold an inquest. This may appear to be too simply stated but from my experience it is a good rule to follow."

Dr. Cotnam stated however that he felt the governing law was set out in Section 10(1) which reads:

> "Where a coroner is informed that there is in his jurisdiction the body of a person and that there is reason to believe that the person died in any of the circumstances mentioned in section 7, he shall issue his warrant to take

possession of the body and shall view the body and make such further investigation as is required to enable him to determine whether or not an inquest is necessary."

If the Legislature intended that an inquest should be held in all cases falling within Section 7, it would have said so. Instead, Section 10(1) requires the coroner to determine whether or not an inquest is necessary. It follows that an inquest is not necessary in every case falling under Section 7. If the coroner honestly decides there is no purpose in holding an inquest, then no inquest need be held.

On cross-examination, counsel for Dr. Shulman questioned Dr. Cotnam regarding an article he had written in 1964 in a medical review, entitled "The Case for the Coroners' System". The article read in part [page 1340]:

> "A great wave of publicity has been created in recent months over coroners' inquests in Ontario. Because much of this publicity has been unfavourable to the medical profession, doctors—individually and collectively through the Ontario Medical Association—have sought to turn back the tide.
>
> It has been suggested that the facts concerning certain unusual deaths should not be published.
>
> The authority of the coroner and the coroner's jury have been questioned, and the proposal made that counsel for interested parties should have the right to examine and cross-examine witnesses.
>
> Superficially, this may appear to be a desirable innovation, but there are many undesirable factors involved. Inquests could become marathon trials; the adversary principle of opposing counsel prevailing, and all other rules of evidence and procedure would have to be followed as in other courts. Inquests would no longer be merely courts of enquiry into sudden, violent or unexpected deaths and their surrounding circumstances, which is their primary purpose at present.
>
> If inquests occasionally result in a smearing or tarnishing of its image the medical profession should investigate the reasons. If criticism of doctors is justified, measures should be considered for preventing a repetition. The cure is not to hide the facts by 'sweeping them under the rug', or by holding 'in camera' inquests. The probing and prying society we live in today demands the right to know what is going on.
>
> If we do not police ourselves more stringently, I am convinced some other body eventually will take over and do it for us. Such a catastrophe can be avoided if the medical profession takes appropriate and prompt disciplinary action against incompetents before unnecessary deaths occur."

And from a lecture entitled "When an Inquest Should be Held" [page 1373], given by Dr. Cotnam in 1963:

> "As a result of this investigation a Coroner must decide whether a death is from natural causes or otherwise.
>
> This may appear to be too simply stated but from my experience it is a good rule to follow.
>
> The textbook entitled, 'Jervis on Coroners', which is a recognized authority on these matters, stated in this manner, and I quote:
>
> 'The Coroner, however, has no power to dispense with an inquest in any case where there is a reasonable cause to suspect that the deceased has died

either a violent or unnatural death, or has died in prison, or in such place or in such circumstances as to necessitate the holding of an inquest in accordance with the requirements of the Act.'

In other words, the Coroner is obligated to hold an inquest under these circumstances and has no power to dispense with same.

The Coroner who says, 'I know what caused the death and, therefore, there is no need for an inquest', does not understand his duties and responsibilities. To know the cause of death is most important but this, in itself, does not supply all the answers to the questions when, where, how and by what means John Doe came to his death."

Dr. Cotnam stated that he still held the same views. This would indicate that he no longer had the doubts expressed in his letter of October 22, 1961, in which he asked:

> "Would you drop me a line and advise me in this case? Should we try to keep our professional colleagues and nurses and hospitals out of the unfavorable limelight of inquests and newspaper columns as far as possible in co-operation with the Crown-Attorney or should all these cases be given the publicity—unfavorable or otherwise—that goes with holding investigations and inquests?"

There can be no doubt that where the facts warrant an inquest, unfavourable newspaper publicity should not be a deterring factor.

Under the Terms of Reference I am to inquire whether any member of the government or senior official of the Department of the Attorney General unlawfully or improperly suppressed evidence relating to the Barbara Moore investigation. The Supervising Coroner in October of 1961 was Dr. Lawson. Dr. Shulman made no specific allegation against him. The letter from Dr. Lawson to Dr. Cotnam sets out the accepted practice at that time, and his advice and opinion in relation to this matter. Dr. Lawson's advice was both lawful and proper. In my opinion Dr. Lawson's advice does not constitute an improper suppression of evidence.

In 1961, Dr. Cotnam was not a senior official of the Department of the Attorney General. Strictly speaking, within the Terms of Reference, I did not need to inquire into his conduct, but because he is the present Supervising Coroner for Ontario and because the allegation was made against him, I did so.

The evidence indicates that when he was a local coroner in 1961 he did not submit a written report to the local Crown Attorney as required by the Coroners Act, but he did submit an oral report. The memorandum prepared by the Crown Attorney on October 13, 1961, indicates that the report was comprehensive. The omission to report in writing may have been neglect, but it was not an improper suppression of evidence. He did prepare the death certificate and set out the cause of death in detail. There was no suppression of evidence in it. He did not notify the parents of the cause of death. Dr. Cotnam, before deciding whether or not an inquest should be held, discussed the case with both the Crown Attorney and the Supervising Coroner. Neither thought an inquest was necessary. There was no evidence to suggest that his decision was not an honest one, and on the evidence I do not see how it could be said that in this case he

unlawfully or improperly suppressed either an inquest or evidence in relation to an inquest, although Dr. Cotnam admits that if he were confronted with the same situation today, he would hold an inquest. His position in that regard seems to have been consistent since 1963, as stated in his articles and lectures already referred to.

Although Dr. Shulman's allegation was specifically against Dr. Cotnam and Mr. Wishart, I am not too clear as to what specific conduct of the Attorney General he alleges was unlawful or improper. His counsel submitted no argument on this point. The Attorney General was not consulted about holding an inquest until years after the decision had been made by the local coroner. After securing a report on the matter, the Attorney General agreed with Dr. Shulman that no inquest should be held. If it was agreed that an inquest at that time would serve no purpose, what then did he suppress? I know of no evidence that was produced which would support this allegation.

SOMORDOLEA INQUEST

Edith Somordolea died in Hamilton on October 1, 1964. She was admitted to St. Joseph's Hospital on August 28, 1964, for treatment of body burns. The attending physician called in Dr. A., a surgeon, who performed débridement of the burned areas under anaesthetic on September 18. There was considerable loss of blood and Dr. A. ordered a transfusion of 2,000 cc.'s the next day. Only 1575 cc.'s were given in a 21½ hour period because the patient showed a slight reaction. On September 30 she was prepared for a skin graft and on Dr. A.'s orders 2,000 cc.'s of blood were administered in a 13½ hour period. On the morning of October 1 the operation was cancelled by the anaesthetist, Dr. Best, because Mrs. Somordolea was in poor condition. She died the next day.

The death was reported by the hospital to a local coroner, Dr. Bulford. An autopsy was performed by Drs. Yaworsky and Haggar, who completed both the form required under the Coroners Act and a hospital form. The former, received by Dr. Bulford, made no reference to a blood transfusion. The latter said the marked change in the patient's condition on October 1 "was felt to have been the result of overloading by transfusion". The coroner did not see this. Dr. Bulford also attended a meeting of the Death Review Committee at the hospital, where there were conflicting opinions as to whether the blood transfusion contributed to the death. Dr. Bulford, after investigating the death, decided that no inquest should be held. He made a report of his investigation to the Supervising Coroner's office, describing the history of the deceased in considerable detail but making no mention of any blood transfusion. He also signed the death certificate, which contained no mention of blood transfusions.

On November 3, 1964, the Medical Advisory Committee of St. Joseph's Hospital considered the matter and by resolution reduced the privileges of Dr. A. in connection with burn cases.

On January 18, 1965, Mr. McAuliffe, a reporter of the *Hamilton Spectator* telephoned Dr. Cotnam regarding the death of Mrs. Somordolea. He had secured certain information from a source at St. Joseph's Hospital and from Dr. Shulman. Mr. McAuliffe outlined to Dr. Cotnam his information and later, at the hearing, testified that on January 18 Dr. Cotnam stated he did not believe an inquest was necessary. Mr. McAuliffe then spoke to the Attorney General who said he would investigate the matter. Following this, Mr. McAuliffe spoke to Dr. Shulman and told him what had taken place. Dr. Shulman then wrote to the Attorney General on January 18.

Dr. Cotnam on January 20 telephoned Dr. Williams, the Medical Director of St. Joseph's Hospital, and requested copies of all documents, including the entire record of the patient.

On January 22 Dr. Cotnam reported to the Assistant Deputy Attorney General that after reviewing the medical records "it is apparent to me that there is sufficient grounds for an inquest which should have been held in the first place".

He requested a direction to conduct the inquest himself and this was granted. Dr. Shulman wrote the Attorney General on January 25 protesting the decision that the inquest be held by Dr. Cotnam on the ground that Dr. Cotnam had already been quoted as saying that the deceased died of natural causes and no inquest was necessary.

An investigation was carried out in Hamilton by Dr. Cotnam and Inspector McBride of the Ontario Provincial Police.

This was one of the cases mentioned by Dr. Shulman in which he alleged that there was an unlawful or improper suppression of evidence in relation to an inquest. Since the death took place outside Toronto, the Terms of Reference were broadened to cover the matter. The person against whom the allegation was made was Dr. Cotnam.

The records from St. Joseph's Hospital were produced by Dr. J. B. Galloway, the Medical Director of the Hospital. His immediate predecessor, Dr. K. J. Williams, was the medical director of the hospital at the time Mrs. Somordolea was a patient. St. Joseph's Hospital is a public hospital with by-laws approved by the Ontario Hospital Services Commission by Order-in-Council. Under these by-laws there is a provision for a Death Review Committee and for a Medical Advisory Committee. The minutes of a meeting of the Death Review Committee for the month of October, 1964 were produced. Present at the meeting were Dr. J. B. Osbaldeston, the Chief of Staff; Sister Mary Grace, the Administrator; Dr. K. J. Williams, the Medical Director; Dr. Kyles, the Head of Anaesthesia; Dr. Goldberg, the Head of Medicine; Dr. Lane, the Head of Surgery; Dr. A., the attending surgeon; Dr. Connell, the Chief Coroner for the City of Hamilton; and Dr. Bulford, the Coroner. The latter three were invited as guests. The minutes read as follows:

> "In his opening remarks the chairman stated there appeared to be unusual circumstances surrounding the death of this patient which necessitated the review. Particularly was this the case inasmuch as the coroner had been notified by presumably a nurse on the floor at the time of death. He stated that the two coroners were welcome to sit in on this death review and that the medical staff of this hospital had a mechanism for reviewing deaths and paying particular attention to any death occurring in the hospital in which circumstances might be open to question. He asked the Medical Director to outline the events leading up to the death and to this meeting.
>
> The Medical Director reported as follows:
>
> This patient was admitted to hospital on August 28, had an operation two weeks later (for débridement etc.). The extent of the burns necessitating the admission were in the neighborhood of 15-20% of her body. She was 68 years of age and presumably in good health apart from the results of the accident. She was booked for surgery on October 1, but just prior to the commencement of surgery in the Operating Room, the case was canceled because of her obviously poor condition. It was at this point that Dr. J. Eydt, an active staff internist was called in on consultation. The patient died later that same night.
>
> On October 2 the coroner phoned the Medical Director stating he had been advised of this death. The Medical Director subsequently wrote a letter to the Chief Coroner officially notifying him. The Medical Director had been advised by the pathologist that it appeared that four bottles of blood, been

given to this patient the day before operation, put the patient into heart failure and was the cause of death. He stated that the pathologist following post-mortem, put the cause of death as acute pulmonary congestion and edema and that this was the prime cause of death. The internist's consultation note and that of the resident in anaesthesia both indicated that the administration of this quantity of blood probably played a role in her death. She was given 2000 cc. of blood the day prior to surgery at which time her hemoglobin was 10.4.

The Medical Director stated there was a question of to what extent this blood caused the patient's death. He emphasized some other aspects revealed by a review of this case as follows:

(a) The patient had been in the hospital one month and apart from the initial history and physical written by the family physician and the initial consultation report by the attending surgeon on August 29, there had been no subsequent recording of any of the patient's progress by the attending surgeon.

(b) There was no pre-operative physical assessment recorded by the attending surgeon or anyone else prior to surgery.

(c) An anaesthetist had not examined this patient, or if he did it was not recorded, on the night prior to surgery.

(d) The very sparse pre-anaesthetic examination by the anaesthetist, Dr. Bota, made no reference to pulse, temperature, urine, or blood pressure and it was recorded on the morning of the proposed surgery.

Several points were brought out in discussion. Dr. Kyles stated that it was Dr. Best who examined the patient the night before and not Dr. Bota. The Medical Director stated at this point that there was absolutely nothing anywhere in the chart to substantiate that Dr. Best had examined this patient. He expressed concern that a physician, who had previously had to substantiate a similar situation, would again find himself in a similar position of stating that he had visited the patient and yet again not recorded it. It appears that both Dr. Kyles and Dr. Best saw this patient in the operating room and that Dr. Best was about to give the anaesthetic, but after conferring with Dr. Kyles it was decided not to do so. There is nothing to this extent recorded anywhere in the patient's chart.

The chairman asked Dr. "A" if the situation as outlined by the Medical Director was correct in his opinion. Dr. "A" stated that it was correct as stated. He also stated that from the comments he heard from nurses on the floor that he was fairly certain they felt the patient was in good condition. At this point the Medical Director referred to the recorded nurse's notes which had stated that at the time she was preparing for the operating theatre she was 'appeared somewhat cyanotic and dyspnoeic'.

The Chief Coroner asked the Medical Director if he felt there was need for an inquest. The Medical Director emphasized that this was a decision to be arrived at by the coroners themselves and that the hospital in no way wished to suggest or influence them whether there should or should not be an inquest.

Dr. Bulford, the coroner assigned to the case stated he felt this patient probably might well have died from other causes. The Medical Director pointed out that it was the coroner who phoned him and stated 'This patient should be alive today'.

The decision reached by this meeting was that the death was not preventable. The Chief Coroner stated that neither he nor Dr. Bulford had mentioned a word of the case to anyone outside of Hamilton and he urged that no details of this case be conveyed to the press."

The minutes of the meeting of the Medical Advisory Committee held on November 3, 1964, were produced and in so far as they pertained to this matter read:

> "Surgeon #"———
>
> "The use of blood transfusions and the part played in an unexpected death of a patient, were discussed. It was pointed out that a special meeting had been called by the Medical Director consisting of the chief of staff, the heads of the departments of medicine, surgery and anaesthesia and the physician concerned plus the administrator and the chief coroner and one of his assistants. Following a detailed discussion of this case it was agreed that the circumstances surrounding this instance and others led to the conclusion that the physician concerned was not knowledgeable regarding the requirements and complications of intravenous therapy. On the motion made and seconded it was voted that a meeting should be held with the surgeon in question with the chief of staff, the head of the Department of Surgery and the Medical Director at which time the concern of the Medical Advisory Committee should be expressed and that they feel it necessary to require him henceforth to have a consultation with a member of the active staff, Department of Internal Medicine on all future burn cases, and that if for any reason he wished to question this requirement he would be welcome at a meeting of the Medical Advisory Committee where this matter could be discussed further."

Dr. J. B. Osbaldeston, Chief of Staff of St. Joseph's Hospital, was present as Chairman of both the Death Review Committee and the Medical Advisory Committee. At the Death Review Committee he expressed the opinion that the blood transfusion played a part in the woman's death. Other doctors present at that meeting were of the opinion that the blood transfusion did not play a part in the woman's death. There was a free and open discussion about the matter. The decision of the meeting was recorded but he did not subscribe to the decision reached by the majority. After this meeting Dr. Osbaldeston was informed by Dr. Connell that the Coroners felt there was no need to call an inquest in this case.

Dr. Osbaldeston testified that subsequently, at the meeting of the Medical Advisory Committee, the decision was reached that the blood transfusion did play a part in this woman's death. Following the meeting of the Medical Advisory Committee, the privileges of Dr. A. were limited to the extent that in all burn cases he was required to have a consultation with an internist on the active staff.

Dr. Osbaldeston was also a witness at the inquest which was held in February of 1965 and gave the same opinion at that time. It was Dr. Osbaldeston's recollection that at the inquest Dr. Williams and Dr. Lane expressed opinions similar to his.

Mr. Gerald McAuliffe, a reporter-photographer for the *Hamilton Spectator*, among other things was assigned to cover inquests. He sought and obtained permission from his editor to write a background story on the manner in which inquests were being conducted in Hamilton. He telephoned Dr. Morton Shulman to find out whether or not there were any specific rules of procedure which coroners must follow in the City of Toronto, and he later received from Dr. Shulman a copy of the Coroners Act with explanatory notes which had been

written as a guide for a coroner. In the course of Mr. McAuliffe's research a death came to his attention which appeared to him to be irregular. Although he did not know the name of the woman, he heard that a blood transfusion was a contributing factor in the cause of death, so he set out to find out who she was.

He had the names of thirty-five women taken from death notices in the *Hamilton Spectator*, and he asked Dr. Shulman if he could check their death certificates, obtain the particulars and thus find out the name of the person he was inquiring about. He could not secure this information himself, since such information is confidential and only given out to certain persons. Dr. Shulman did so. One of the names was that of Edith Somordolea. On the basis of the information he received from Dr. Shulman, Mr. McAuliffe telephoned Dr. Bulford who had signed the death certificate. Although not sure of the exact date, Mr. McAuliffe thought the conversation took place about January 17. But as the photostat copy of the death certificate is dated January 18, the conversation probably took place on the eighteenth.

Mr. McAuliffe stated that he told Dr. Bulford over the telephone that it was his understanding that this was a case of the woman who fell into a bath tub in an intoxicated condition some time in August. She sustained rather severe burns to her body and was admitted to hospital the following day. Some three weeks later she was being prepared for plastic surgery and on orders from Dr. A. received 2,000 cc.'s of blood. She had a heart condition, complications developed, and he understood that blood had seeped into her lungs and drowned her. Dr. Bulford, according to Mr. McAuliffe, advised him that the matter boiled down to medical judgment, that there was a dispute among people who were familiar with the case as to whether or not blood had contributed to her death and whether or not Dr. A. had in any way been negligent. Mr. McAuliffe stated that Dr. Bulford agreed that the blood might have been a contributing factor, but it was his opinion that it was an irrelevant contributing factor and as far as he was concerned it was a death from natural causes. A disagreement arose between Mr. McAuliffe and Dr. Bulford when Mr. McAuliffe suggested that the death certificate was incorrect, and Dr. Bulford hung up.

Mr. McAuliffe then telephoned Dr. Connell, the Chief Coroner at Hamilton. Dr. Connell stated that he didn't believe the matter was one that warranted an inquest.

Mr. McAuliffe telephoned Dr. Cotnam, he thought about January 18, and according to Mr. McAuliffe he outlined to Dr. Cotnam everything he had discussed with Dr. Bulford. Dr. Cotnam told him that nothing of this matter had been brought to his attention, he had no idea who Edith Annie Somordolea was, and that his office at that time had received absolutely no complaints from anybody about the matter. Mr. McAuliffe stated that he asked Dr. Cotnam if he thought this was a case that warranted an investigation, and that Dr. Cotnam said that he did not believe an investigation should be launched every time a newspaper called and that he was not prepared to do anything until he had obtained particulars from the people concerned with the death.

Following his conversation with Dr. Cotnam, Mr. McAuliffe telephoned the Attorney General, explained what he had told Dr. Bulford, Dr. Connell and

Dr. Cotnam and advised him that Dr. Cotnam did not believe the matter warranted further investigation, but that he, McAuliffe, was still convinced that the death certificate was false and that there were circumstances that warranted an investigation. Mr. Wishart advised him that he would instruct the Director of Public Prosecutions to begin an investigation at once and Mr. McAuliffe would be notified within a couple of days. Mr. McAuliffe's story in the *Spectator* was printed January 19 and in it he announced that the Attorney General was going to investigate the death of Mrs. Somordolea. A few days later Mr. McAuliffe telephoned Dr. Cotnam and learned that an inquest would be held.

Dr. Shulman testified that he first heard from Mr. McAuliffe during the first week of January, 1965, when he had inquired as to whether there were any guides to the conduct of coroners. A day or two later Mr. McAuliffe called again saying that he had information that a woman had died as the result of an overdose of blood and a meeting had been held at which the coroners agreed not to hold an inquest. He knew that she was one of thirty or thirty-five women who had died about the same time, and he would appreciate Dr. Shulman's help in getting the name of the woman.

As a result of this call, Dr. Shulman started going through death certificates. He obtained photostat copies from the office of the Registrar of Vital Statistics. These certificates come in two parts, one signed by the funeral director, the other by a doctor or coroner. The certificate of death of Mrs. Somordolea, signed by the coroner, said that death was the result of an accident on August 26, 1964, and the date of death was October 1, 1964. It said that the cause of death was pulmonary edema and congestion of the lungs. According to Dr. Shulman this is not what one normally dies of if one dies of a burn. There was no reference on the death certificate to blood. Dr. Shulman then called Mr. McAuliffe and gave him the information he had found. Mr. McAuliffe indicated to Dr. Shulman that the source of his information was a senior physician at the hospital.

Dr. Shulman testified that on January 17 he spoke to Mr. McAuliffe again. At that time Mr. McAuliffe informed him that he had been in touch with Dr. Bulford, Dr. Connell and Dr. Cotnam and none of them felt that any further investigation was required or that an inquest was necessary. Dr. Shulman testified that he then telephoned Dr. Bulford on January 17.

Since the photostat of the death certificate from the Registrar of Vital Statistics was dated January 18, it would seem that that was the day on which Dr. Shulman learned the name of Mrs. Somordolea, and that he telephoned Mr. McAuliffe and Dr. Bulford on that date. Dr. Bulford advised him that he had sent the full report to Dr. Cotnam, that the matter was not in Dr. Shulman's jurisdiction, and that the case was none of his business. The same day, January 18, Dr. Shulman sent a letter to the Attorney General, which reads in part as follows:

> "*Re Edith Annie Somordolea—deceased.*
>
> Very grave accusations have been forwarded to me in connection with the death of the above woman. This sixty-eight year old woman died in St. Joseph's Hospital, Hamilton on October 1st, 1964, following a one month hospitalization for burns. Following her death the coroner Dr.

Bulford was notified and he and the chief coroner Dr. Connell then are alleged to have attended a meeting of the medical advisory board of St. Joseph's Hospital, at which time it is alleged that a discussion took place indicating that Mrs. Somordolea died as a result of medical negligence in connection with certain blood transfusions. At this time it is my understanding that the doctor involved was instructed that he in future would not be allowed to carry out the medical procedures performed in this case. I am further informed that at this time Dr. Connell agreed not to hold an inquest providing that all present would promise that under no circumstances would they reveal the facts.

This case appears especially serious because Dr. Bulford assured me today that Dr. Cotnam was aware of all the facts and that a copy of Dr. Bulford's report had been forwarded to Dr. Cotnam."

When Dr. Shulman wrote this letter he had not of course seen the minutes of the Death Review Committee or of the Medical Advisory Committee.

On January 25 Dr. Shulman wrote again to the Attorney General. The letter reads as follows:

"Dear Mr. Wishart: It is with the greatest dismay that I have learned today that Dr. H. B. Cotnam is to hold the inquest into Mrs. Somordolea's death. You will recall from my previous letter that Dr. Cotnam had been named by Dr. Bulford as being fully aware of the facts from the beginning. In effect, the situation now is that a man suspected of suppressing certain facts from the public is to direct an inquiry to look into these facts. It may be that Dr. Bulford was in error and Dr. Cotnam was not fully informed throughout. This week, however, Dr. Cotnam has been quoted as saying that the deceased died of natural causes and no inquest was necessary.

Under these circumstances if Dr. Cotnam presides at this inquest, there will be a grave suspicion that this case is being whitewashed. I hope you will make other arrangements."

The Attorney General acknowledged receipt of these letters and others on February 10, and his letter refers to several matters.

Dr. Shulman was questioned regarding the contents of his letter of January 18 to the Attorney General. He wrote the following paragraph because of information he received from Mr. McAuliffe:

"Following her death the Coroner Dr. Bulford was notified and he and the Chief Coroner Dr. Connell then are alleged to have attended a meeting of the Medical Advisory Board of St. Joseph's Hospital, at which time it is alleged that a discussion took place indicating that Mrs. Somordolea died as a result of medical negligence in connection with certain blood transfusions." [Page 1727 lines 16-26]

The evidence was that it was the Death Review Committee, not the Medical Advisory Committee, and the minutes of the meeting indicated that it was the opinion of the majority that the death was *not* preventable, not that Mrs. Somordolea died as a result of medical negligence. The next sentence of Dr. Shulman's letter to the Attorney General reads:

"At this time it is my understanding that the doctor involved was instructed that he in future would not be allowed to carry out the surgical procedures performed in this case."

This statement is not quite accurate. It was at a later meeting that a limitation on the surgeon's work was considered. There was no criticism of the surgical procedures since no surgery was performed. The limitation related to the necessity of holding a consultation with an internist before ordering blood in a burn case. The next sentence reads:

> "I am further informed that at this time Dr. Connell agreed not to hold an inquest providing all present would promise that under no circumstances would they reveal the facts."

This is not in accord with the minutes of the meeting. Dr. Connell urged that no details of the case be conveyed to the press, but there is no reference to any agreement. The next sentence stating "that Dr. Cotnam was aware of all the facts" is also not supported by the evidence. There is a conflict between Dr. Shulman and Dr. Bulford as to what was said, but an examination of Dr. Bulford's report makes it clear that as of January 18 Dr. Cotnam did not have all the facts.

Inspector McBride of the Ontario Provincial Police was assigned to assist with the investigation and preparation of the brief. He and Dr. Cotnam went to Hamilton to interview the witnesses and take statements. He prepared a brief for the Crown Attorney and saw that all witnesses were called that could give any useful evidence. They were examined by Mr. Harvey McCullough, one of the most experienced Crown Counsel in Ontario.

Dr. W. S. T. Connell was the Chief Coroner for Hamilton when this death occurred. Although he has since retired, he had been carrying on a medical practice in Hamilton since 1914. When he was advised of the death of Mrs. Somordolea by St. Joseph's Hospital, he appointed Dr. Bulford as coroner on the case. Dr. Bulford investigated the death and discussed the matter with him. Although Dr. Connell did not see the coroner's post-mortem report, Dr. Bulford told him about it. Both were invited to attend a meeting on October 9 of the Death Review Committee. They attended as guests but took no part in the meeting. After the meeting was over Dr. Connell and Dr. Bulford went outside, talked the matter over, reached a decision, then went back in and advised the meeting that an inquest would not be necessary. They were not directed to come to this decision by anybody or asked by the hospital not to have an inquest. Considering that the woman was badly scalded, that she was at home for some hours before being admitted to hospital, and that she was in hospital under the care of several specialists for some length of time, Dr. Bulford thought an inquest was not necessary. When asked what conclusion he arrived at as to whether the transfusion of too much blood had caused the death of this woman, he stated that as an industrial surgeon he had given far more blood than that in accident cases. He also pointed out that seventeen or eighteen hours had elapsed from the time this woman had received the blood until she died.

Dr. H. E. Bulford carries on his medical practice in the City of Hamilton. He graduated in 1933 and has been a coroner since 1956. He was appointed by Dr. Connell to investigate Mrs. Somordolea's death. Dr. Bulford testified that while making inquiries at the hospital he learned of the blood transfusion and that there was a question of whether blood had played some part in the death.

He telephoned Dr. Williams, received certain information, and at that time said, "This woman should not have died.' He said that he made this statement before he had all the facts. He ordered a post-mortem examination and received a verbal report from the Regional Pathologist, Dr. Haggar, that death was due to acute pulmonary congestion and edema and that extensive burns to the body was a factor. Dr. Bulford prepared the death certificate, giving this cause of death. The written report from the pathologist came in a few days later, confirming his oral report.

One question on the death certificate reads: "If the death was due to violence state whether it was an accident, suicide or homicide." Dr. Bulford testified that since he felt that the death was indirectly due to an accident which had occurred when the woman fell into the tub, he put down the word "accident" in answer to this question.

Dr. Bulford testified that when he first went to the hospital he had the impression that he was dealing with a case of pulmonary edema due to an overdose of blood. After discussing the case with a specialist in internal medicine, he changed his mind.

He stated that Dr. Connell was invited to attend the Death Review Committee on October 9 and asked him to go along. By this time Dr. Bulford had made up his mind that an inquest was not necessary. He told this to Dr. Williams before the meeting started. He heard the discussion amongst the doctors at the Death Review meeting and during the meeting he and Dr. Connell stepped outside. At that time he told Dr. Connell that he could see no reason for changing his mind. Dr. Bulford then prepared and submitted his investigation report to Dr. Connell.

In Dr. Bulford's report of October 16 there is no reference to a blood transfusion. He stated that this was left out because in his opinion it did not play any part as far as the cause of death was concerned. He felt there was no need to mention the blood transfusion unless it played an important part and he did not think it did. He was not directed by anybody not to hold an inquest. He and Dr. Connell reached the decision, after consultation, that an inquest was not necessary. Although Dr. Bulford considered that the burns had contributed to some extent to Mrs. Somordolea's death, he felt it was questionable, after six weeks' treatment in hospital, whether the death should be called accidental or natural.

After he filed his report on October 16 with the Chief Coroner, the case was closed so far as he was concerned. He next received a telephone call from a person representing himself to be on the staff of the *Hamilton Spectator*. Dr. Bulford told him nothing. He then received a telephone call from Dr. Shulman. He told Dr. Shulman that the latter's authority did not extend beyond the County of York, that he had filed his investigation report and any information that Dr. Shulman wished could be obtained from Dr. Connell or Dr. Cotnam. Dr. Bulford said that he was a little bit upset to think that a qualified coroner should want him to divulge confidential information.

Later he received a call from Dr. Cotnam. He told him that he had filed his report and that Dr. Cotnam had better take a look at it.

The evidence given by Dr. Bulford at the inquest was reported in the *Hamilton Spectator* in part as follows:

> "He said he changed his mind about having an inquest after talking to Dr. John Eydt, a specialist consultant in internal medicine at St. Joseph's."
>
> "The chief point that made me change my mind was that this woman had an attack at 9:00 a.m. in the morning and she had ample time to be treated and yet she died at 11:00 p.m. that night."
>
> "He insisted Mrs. Somordolea's death was caused by a heart condition but did admit 'the blood may have overtaxed her heart'."

Dr. Bulford was referred to the letter written by Dr. Shulman, following his telephone conversation with him, as follows:

> "Following her death the coroner Dr. Bulford was notified and he and the Chief Coroner Dr. Connell then are alleged to have attended a meeting of the Medical Advisory Board of St. Joseph's Hospital at which time it is alleged that a discussion took place indicating that Mrs. Somordolea died as a result of medical negligence in connection with certain blood transfusions."

Dr. Bulford stated that he did not hear any discussion about this question at the meeting he attended. As to Dr. Shulman's statement—

> "I am further informed that at this time Dr. Connell agreed not to hold an inquest provided that all present would promise that under no circumstances would they reveal the facts."—

Dr. Bulford said that this was absolutely incorrect.

Dr. Cotnam testified that Dr. Bulford's investigation report was received in the office of the Supervising Coroner on October 20, 1964. It was screened by Mr. John E. J. Hills on the same day. During the year 1964 approximately seventy-five reports came in daily to the office of the Supervising Coroner. Mr. Hills would screen the reports as they came in. If he saw anything unusual he brought the matter to Dr. Cotnam's attention and the latter reviewed it. The Somordolea report was not brought to his attention.

Dr. Cotnam testified that on January 15, 1965, Mr. McAuliffe telephoned him and asked him whether he was aware of certain circumstances surrounding the death of Mrs. Edith Annie Somordolea. Dr. Cotnam said he could not even recall the name, let alone the circumstances. Dr. Cotnam then checked his file and had a further conversation with Mr. McAuliffe. The only document in the file was the Coroner's Investigation Report. The report appeared to be complete and he saw nothing alarming in it. Dr. Cotnam told Mr. McAuliffe that according to the report there was nothing to justify any further investigation, and that if he would check with Dr. Bulford and Dr. Connell in Hamilton perhaps they could give him whatever information he required.

Dr. Cotnam then called Drs. Bulford and Connell and asked each of them if anything further had come to their attention since he had received the Coroner's report which might alter their previous opinions that no inquest was required. They assured him that there was nothing further to alter their opinions regarding an inquest. At that time Dr. Cotnam felt no inquest was necessary. Shortly after this the Attorney General's Department was in touch with him. Dr. Cotnam was asked to look into the matter to see if there was anything which had been missed. He then contacted Dr. Robert Haggar, the Chief Pathologist at St. Joseph's Hospital in Hamilton, and Dr. Kenneth Williams, the Medical Director of the Hospital. They informed him of the sequence of events that led up to this death, to which no reference had been made either in the Coroner's report or in the telephone conversations with either Dr. Bulford or Dr. Connell. It was not until he spoke to Dr. Williams on January 20 that Dr. Cotnam was in a position to consider that a further investigation might be required.

Dr. Cotnam testified that when he first spoke to Dr. Bulford, Dr. Bulford assured him that death was from natural causes. Nothing was said about blood transfusions. After talking to Drs. Williams and Haggar, Dr. Cotnam called Dr. Bulford back and specifically mentioned the blood transfusion. Dr. Bulford told him that the excessive amount of blood was not significant. When he got the original material from Dr. Willams, it appeared on the surface that this woman did get an overdose of blood which caused her death, and if this were true then certainly an inquest was indicated. After reading the information supplied by the hospital, Dr. Cotnam was satisfied in his own mind that relevant information had not been reported to his office and that the medical certificate of death did not tell the whole story. Following the receipt of the hospital records and other relevant correspondence, Dr. Cotnam thought there should have been an inquest. He held this opinion up until he took statements from those personally involved and heard the evidence at the inquest on February 25 and 26.

When the investigation was completed there was conflicting evidence as to whether the blood had in fact been a factor and had caused death. Dr. Cotnam stated that the evidence indicated that at the very most it could have been a contributing factor. In addition there was evidence at the inquest that the woman had a heart condition which was not recognized prior to death. It was recognized at the autopsy. Dr. Cotnam said the omission from the certificate under the Coroners Act, of any reference to blood might lead a local coroner astray in completing the death certificate. He pointed out that there was no mention of excessive blood transfusion in the summary of "Cause of Death" by the gentlemen who did the original autopsy. This form was signed by Dr. Haggar and Dr. Yaworsky. Dr. Cotnam insisted that at the inquest there was a conflict of opinion about whether the administration of a certain volume of blood in a certain period of time was a contributing factor. He stated that his opinion conflicted with those of the hospital doctors, as did the opinion of Dr. Bulford, Dr. Connell and the attending surgeon. Another witness, Dr. J. M. Eydt, when asked by the Crown Attorney if the blood transfusions might have caused her death, replied: "I can't say that it did or it didn't."

What Dr. Cotnam said to the jury, as taken from the transcript of the inquest, was as follows:

> "After complete investigation, both coroners concluded that death was from natural causes, and there was no evidence of neglect, negligence, or foul play, and therefore there was no need for an inquest since it would serve no useful purpose.
>
> The coroner is given the authority under the Coroners Act to make this decision. In the first instance, as to whether an inquest is required or not. Perhaps if I told you that our coroners in Ontario investigated 18,000 deaths annually, or about 30% of the total deaths in the province, but only approximately 1,500 or 8% come to inquests and you can better appreciate the fact that coroners must decide daily whether an inquest is necessary or not. Their decisions can only be overruled by the Crown Attorney or by the Attorney-General, which is seldom done, and seldom necessary.
>
> It was overruled in this case by the Attorney-General, not necessarily because he disagreed with the coroners' decision regarding the inquest, but rather because of the many nasty and vicious complaints and rumours involving the doctors and also the coroner in this case, and the Attorney-General decided that an inquest was necessary to clear the air and he directed me to hold this inquest for that purpose, as Supervising Coroner, because I am more or less an independent third party not connected with this case in any manner; and, as I stated, the coroners involved in this case decided that no inquest was necessary, and after hearing all the evidence, I agree with their original decision."

I have set out Dr. Cotnam's charge to the jury so that it may be examined if necessary to decide whether or not it was fair. The jury had heard all the evidence. It is not for me to determine what weight the coroner's jury should attach to the evidence of the various persons. Clearly there was a conflct in the evidence, and it was up to the jury to decide. Dr. Cotnam's charge to the jury expressed his opinion but it was not improper to express an opinion to a jury, especially when he made it clear that they were not bound by his opinion but were to reach their verdict based on the evidence. The inquest having been ordered by the Attorney General, Dr. Cotnam's comments as to the earlier decision not to hold an inquest, his agreeing with that original decision after hearing all the evidence, and the references as to why the inquest was ordered, were in my opinion completely irrelevant and ought not to have been made.

Dr. Cotnam was asked if he had attended the Death Review meeting and read the autopsy, would he have mentioned blood if he were completing the death certificate. He replied that he might mention it but not necessarily. He was referred to a memorandum to Coroners of January, 1964, in which he said:

> "Where there is any indication that the death was not from natural causes he should hold an inquest."

Dr. Cotnam said his remarks were guide-lines for the coroner but not necessarily what he must do.

Dr. Cotnam said the decision to hold or not to hold an inquest in this case was the decision of Dr. Connell and Dr. Bulford in the initial stage. He was not consulted in any way about that. This is normal practice, to leave the decision

to the Coroner seized with the case. The first time his office would come in touch with the matter would be when the report of the investigating coroner was received. The report filed by Dr. Bulford was examined by Mr. Hills and filed. After the matter was brought to Dr. Cotnam's attention by Mr. McAuliffe, he read the report but there was nothing in it which aroused his suspicion. At the time of the Somordolea investigation, autopsy reports did not need to be filed with the Supervising Coroner as they now do. Although Dr. Cotnam said it would have been preferable if Dr. Bulford had put something in the investigating report about the blood transfusion, that decision would depend upon the opinion of the individual coroner as to whether this factor did or did not have any relation to the cause of death. If a coroner concluded as a matter of his own medical judgment that a certain factor did not relate to the cause of death, then he might or might not put that matter in his report.

It may be that Dr. Bulford was influenced to some extent by the majority decision of the Death Review Committee. Apparently his views coincided with those of the majority. He may also have been influenced by the autopsy report. Dr. Bulford filled out the death certificate using almost the same words as the pathologist. The pathologist in his report certified that the cause of death was "acute pulmonary congestion and edema". Dr. Bulford in filling out the death certificate gave the cause of death as "pulmonary edema and congestion of lungs". It was the opinion rightly or wrongly of Dr. Bulford and Dr. Connell that death was caused by heart failure due to unanticipated complications. The jury, after hearing evidence from all the doctors concerned, reached the same conclusion.

In this case where it is alleged that there was unlawful and improper suppression of an inquest, specifically by Dr. Cotnam, Dr. Shulman was referred to Dr. Bulford's report. After reading the report, Dr. Shulman was questioned as follows:

Q. You agree there is no mention in this investigative report about blood being administered?

A. Yes, sir.

Q. Yet you are stubborn enough to persist in your accusation?

A. I am saying, sir, this is a clear case where an inquest should have been held. [Page 1748 lines 8-15]

Dr. Shulman was being evasive. The issue in question was whether Dr. Cotnam, after receiving the investigation report, was "aware of all the facts" and had suppressed them from the public, not whether an inquest should have been held.

Mr. P. W. Moon, a reporter from the *Hamilton Spectator*, was called by Dr. Shulman.

When this witness was first called, a question was raised as to the relevancy of his evidence for it dealt with what was said by Dr. Cotnam in August of 1966, long after the inquest in question. Counsel for Dr. Shulman stated that Mr. Moon's evidence had a direct bearing on the testimony that Dr. Cotnam had given earlier when questioned about views he had held in January of 1965, and

on Dr. Cotnam's present views on practices relating to the Coroner's office. Since the evidence might have some relevancy in this regard I permitted the examination to proceed.

Mr. Moon interviewed Dr. Cotnam in August or September of 1966. At that time Dr. Cotnam told Mr. Moon that he felt the reporter McAuliffe had done an excellent job and that in his opinion an inquest was justified in this case. He said that Dr. Cotnam told him there was no doubt that facts had been suppressed from him in Hamilton. It was Mr. Moon's opinion that Dr. Cotnam had done a considerable amount to improve the coroners' system in Ontario.

I do not think that I need decide whether a transfusion of blood contributed to the death of this woman. There was obviously a conflict of medical opinion on that point, both at the meeting of the Death Review Committee and at the inquest. Dr. Bulford has sworn that in his opinion the effective cause of death was a heart attack, although Mrs. Somordolea's condition brought about by burns may have been a contributing factor. He reached this decision after discussing the case with a specialist in Internal Medicine and after hearing conflicting opinions at the Death Review Committee. There was no evidence to suggest that Dr. Bulford's decision was not an honest one. Whether or not it is a clear case in which an inquest should have been held could have nothing to do with supposed suppression of an inquest by Dr. Cotnam, if the matter was not referred to Dr. Cotnam until three months later.

This present inquiry is directed to inquire whether the Government or any senior official of the Department of the Attorney General unlawfully or improperly suppressed evidence, and the specific allegation made by Dr. Shulman was against Dr. Cotnam. Counsel for Dr. Shulman submitted that although Dr. Cotnam recommended an inquest, he condoned and endorsed the decisions of the Hamilton coroners who had suppressed the facts. I am concerned with whether Dr. Cotnam unlawfully or improperly suppressed evidence in relation to this inquest, not whether he condoned any decision made by Dr. Bulford. There was nothing in the investigation report to justify the ordering of an inquest, but when Dr. Cotnam learned that a blood transfusion might have played a part in this woman's death he agreed that an inquest should be held. The inquest was open to the public and all witnesses who could give any relevant evidence were called. On the basis of these facts I do not think it could be said that Dr. Cotnam had unlawfully or improperly suppressed evidence in relation to this matter.

MAGEE INQUEST

Early in the inquiry Dr. Shulman alleged that in this case there had been an unlawful or improper suppression of an investigation or inquest, and as a result the Terms of Reference were amended to inquire into this matter. [Page 592 line 19 to page 604 line 20]. At that time he made no specific allegation against any individual. Because of the general allegation, I inquired into the facts in relation to this death.

When asked what his allegation was in this case, Dr. Shulman replied [page 2292 line 30 to page 2293 line 12]:

A. My allegation, as I have made it clear, was I complained at the time that an inquest should be held in this case regarding medical negligence and for some reason was not held despite repeated prodding from Mrs. St. Louis.

Q. There was an inquest held?

A. Ultimately, yes.

Q. Your complaint goes to delay?

A. Yes, sir.

Q. Anything else?

A. As I have said, I don't think an inquest would have been held if she had not kept pushing. [Page 2292 line 30—page 2293 line 12]

The facts on which Dr. Shulman based his belief were contained in the correspondence forwarded to him from Mrs. St. Louis, a sister-in-law of the deceased.

Dr. Shulman stated that after he received a letter from Mrs. St. Louis with correspondence attached, he sent the following letter by registered mail to Dr. Cotnam on April 29, 1967:

> "I am writing to you about Mr. A. U. Magee, who died six months ago in Brantford. The family inform me they have written several times but as yet have no results. Inasmuch as this case may involve medical negligence I request that you hold an immediate inquest." [Page 2289 lines 11 to 17]

Dr. Shulman stated that he did not receive any acknowledgement of this letter. A copy of a letter from Dr. Cotnam to Dr. Shulman dated May 10, 1967, was produced by Dr. Cotnam. The letter read as follows:

> "Dear Dr. Shulman:
>
> This is to acknowledge your letter of April 29th, 1967, with reference to the above deceased person. Thank you for bringing this important matter to my attention and I can assure you that it was well in hand." [Page 2292 lines 6-12]

Mrs. St. Louis' first letter to Dr. Cotnam, asking him to look into the matter, was dated November 21, 1966. Dr. Shulman agreed that if in fact the office of the Supervising Coroner had decided as early as November 9 to hold an inquest, which would be twelve days before the letter was sent by Mrs. St. Louis, then there would be no basis for his allegation. [Page 2294 line 29 to page 2295 line 7]

Because the truth or falsity of the allegation would seem to turn on the dates certain decisions were made, I have set forth the dates with particularity.

Arthur U. Magee died in hospital at Brantford on October 2, 1966, presumably from tetanus. A few days after the death occurred, Dr. Clarke, the investigating coroner, telephoned Mr. Hills and advised him of the circumstances relating to the death. An autopsy was performed by Dr. Croal, a pathologist, and the post-mortem report was forwarded to the Supervising Coroner's office on October 20. Dr. Clarke's investigating report, dated October 24, was received by the Supervising Coroner's office on October 26 and it gave the cause of death as "asphyxia due to collapse of lungs due to tetanus infection resulting from injury on 19th September 1966". Mr. Hills then ordered a copy of the police report concerning the death and a copy of the hospital records. When these were received he forwarded a memo dated November 9, 1966, to Dr. Cotnam, as follows:

> "Re: *Arthur Magee, deceased.*
>
> P. M. report and hospital records now attached. The key to the problem is contained in Dr. Newell's summary 'There was some uncertainty about tetanus toxide being administered'. Inquest should be held. Do you agree?" [Page 2301 lines 10-18]

Dr. Cotnam made a notation on the memo: "I agree", and the initials "H.B. November 9th, 1966". Mr. Hills then sent a memo dated November 10 to Mr. Kenneth Lewis, the Liaison Officer in the office of the Supervising Coroner, as follows:

> "Please advise Dr. Clarke that it is our opinion that an inquest be held, and we would appreciate being informed of inquest date when it has been ascertained." [Page 2302 line 29 to page 2303 line 2]

A letter to this effect was sent by Mr. Lewis to Dr. Clarke on November 16, 1966.

A few days later Mr. Hills received a telephone call from Dr. Clarke who advised him that he would prefer to have the inquest transferred to another coroner due to the fact that the attending physician was a coroner in Brant County and that both were members of the staff of the two hospitals concerned. It is not unusual for a doctor to disclose a conflict of interest and ask to be relieved. According to Mr. Hills, this happens many times and is the proper thing to do. Mr. Hills advised him that he would obtain another coroner to conduct the inquest. He produced a memo dated November 22 to Mr. Lewis, which read:

> "Please phone Dr. Lynne-Davies, Kitchener, and ask if he will take over the inquest. If so, forward copy of our file to him and advise Mr. Borda of situation." [Page 2305 lines 23-28]

Mr. Borda was the Crown Attorney.

Mr. Hills testified that Dr. Lynne-Davies was an experienced coroner and one of the busiest coroners outside Metropolitan Toronto. When asked by counsel for Dr. Shulman why he would pick one of the busiest coroners in the Province, Mr. Hills replied that he wanted an experienced coroner and trusted Dr. Lynne-Davies' judgment and ability.

When Mr. Hills received the letter from Mrs. St. Louis dated November 21, 1966, he forwarded it along with a memo to Mr. Lewis dated November 25, which read:

> "Please acknowledge and advise her that an inquest had previously been ordered and will be held in the near future." [Page 2306 lines 28-30]

On November 28, 1966, Dr. Cotnam sent a letter to Dr. Lynne-Davies, authorizing him to act as coroner and enclosing a photostat copy of his file. Mr. Hill's follow-up letter to Dr. Lynne-Davies on January 25, 1967, read as follows:

> "Would you kindly advise this office as to whether an inquest has been held into the above mentioned death. If an inquest has not been held we would appreciate being advised as to the date, time and place. Your assistance in this matter would be greatly appreciated." [Page 2310 lines 6-12]

Approximately a week later Mr. Hills received Mrs. St. Louis' second letter, of January 30, which read in part:

> "To date I have not received acknowledgement or a reply from you or your office. A reply would be appreciated." [Page 2286 lines 17-19]

At that time he realized that she had not received a letter pursuant to his memorandum to Mr. Lewis of November 25. Mr. Hills then wrote her an acknowledgement dated February 1, 1967, which read:

> "Please accept my apology for not having answered your previous letter dated November 21st, 1966. It has been decided that an inquest will be conducted into the death above mentioned and the presiding coroner will be Dr. G. Lynne-Davies, 9 Pleasant Avenue, Kitchener.
>
> A definite date has not as yet been settled for the inquest. Should you wish to attend the inquest may I suggest you contact Dr. Lynne-Davies direct and so inform him in order that he may advise you when a date is set." [Page 2286 line 26 to page 2287 line 8]

On February 11, 1967, Mrs. St. Louis wrote a letter addressed to Dr. G. Lynne-Davies, requesting permission to attend the inquest and requesting that he advise her of the date when the inquest would be held.

Mr. Hills testified that between the letter of authority to Dr. Lynne-Davies on November 28 and his follow-up letter of January 25, he was in touch with Dr. Lynne-Davies on half a dozen occasions when the matter was discussed. He knew that Dr. Lynne-Davies was having some difficulty in obtaining the appropriate expert witnesses for the inquest. Before he knew the exact date of the inquest, Mr. Hills received a letter from Mr. Frank Drea of the Toronto *Telegram* dated April 24, 1967, which read:

"Dear Jack:

In reference to your letter of February 1st, 1967, to Mrs. Henry J. St. Louis, Box 245, Brantford, Mrs. St. Louis has written to us and, for some peculiar reason known only to herself, is convinced that there still will be no inquest.

Will you please reassure her?

Thank you.

Sincerely,

Frank Drea for Action Line"

[Page 2328 lines 19 to 28]

Mr. Hills stated that he learned on April 28 that the inquest was going to be held on May 16 at 2:00 P.M. at the City Police Station, Brantford. He forwarded this information on to Mrs. St. Louis on May 3, 1967.

Mr. Charles Borda, the Crown Attorney for the County of Brant, was Crown Counsel at the inquest. He said that he received an inquiry from the brother of the widow of the deceased as to whether an inquest would be held and he advised him that there would be an inquest. In November he received another call from the same person who stated that he had information that there would be no inquest. He then called Dr. Clarke who was the investigating coroner at that time who confirmed that an inquest was going to be held. Mr. Borda then tried to assure the deceased's brother that an inquest would be held. It was Mr. Borda who suggested to Dr. Clarke that he should disqualify himself because of a possible conflict of interest, as he was on the staff of both hospitals involved. Later he was advised that Dr. Lynne-Davies would be acting as coroner. The inquest date was fixed, about the middle of April, for June 16. A tentative date had been made earlier but had to be put back.

Dr. Gerald Lynne-Davies graduated in medicine from Oxford University in 1964 and carries on his practice in Kitchener. He is a member of council of the College of Physicians and Surgeons of Ontario. After receiving authorization from Dr. Cotnam to act as coroner in this matter, he got in touch with the Brantford City Police and requested a report into the circumstances surrounding the death of Mr. Magee. A police officer was assigned to assist in the investigation and Dr. Lynne-Davies was in touch with this officer at intervals throughout the next several weeks. He also contacted the Crown Attorney and discussed with him the preliminaries that had to be attended to before the inquest could be held. He was in touch with the office of the Supervising Coroner by telephone and also attended in Toronto to discuss the case with him. He discussed with Mr. Hills the securing of an expert medical witness with knowledge of tetanus. Mr. Hills recommended a Dr. W. T. W. Clarke, a professor of medicine at the University of Toronto and a member of the staff of the Toronto General Hospital. Dr. Lynne-Davies wrote to him on January 7, 1967. He did not receive a reply from Dr. Clarke until January 31, when Dr. Clarke advised him that he was unable to act but recommended Dr. Joseph Hilliard.

Dr. Lynne-Davies replied to Dr. Clarke's letter on February 10 and heard from Dr. Hilliard on March 1. On March 28 he attended in Toronto and dis-

cussed the case in detail with Dr. Hilliard with a view to determining what might be done to prevent further deaths from tetanus. Dr. Hilliard required more information, which Dr. Lynne-Davies procured from the Brantford Police.

The inquest was first scheduled for May 2, then had to be adjourned to May 16. Dr. Lynne-Davies instructed Constable McDonald of the Brantford City Police department to notify Mrs. St. Louis of the date of the inquest and requested that she be subpoenaed in case she had any information that was relevant. He stated that he did not write her a letter in reply to her letter to him because he did not think it would be proper for him to do so.

Dr. Lynne-Davies testified that one of the purposes of the inquest was to find out whether the deceased got any immunization, and if he did, whether it was the correct one. The evidence adduced indicated that the attending doctor, assuming Mr. Magee had had previous injections against lock-jaw, ordered tetanus toxide but the patient did not receive it, nor any injection.

The verdict of the jury was that death was caused by tetanus causing asphyxiation, as a result of an accident causing injury. The jury made eight recommendations, which were based on the opinion evidence given by Dr. Hilliard.

Dr. Lynne-Davies stated that he had nothing to do with the selection of the jury. He testified that at the inquest he asked Mrs. St. Louis whether she was satisfied as a close relative of the deceased that the circumstances of Mr. Magee's death had been fully brought out and she answered in the affirmative. He did feel the inquest was an important one and by reason of the recommendations was a profitable inquest which might help to prevent a similar death in the future.

In this matter it is clear that a full investigation was made by the coroner and all the relevant evidence was brought out at the inquest. The next of kin of the deceased were notified and invited to give any relevant information they might have. The hearing was in public and there is no evidence to suggest that any evidence was suppressed. While it is obvious that there was considerable delay in the holding of this inquest, there were unusual circumstances which caused the original coroner appointed to disqualify himself because of possible conflict of interest; and there was difficulty in securing a qualified expert to give evidence.

When Dr. Shulman mentioned this case at the inquiry he was not in possession of the facts. His allegation that there would not have been an inquest except for the persistence of Mrs. St. Louis was shown to be false. The evidence clearly establishes that the inquest was ordered twelve days before her letter requesting that an inquest be held was received. Dr. Shulman did not inquire as to the reason for the delay. Without any attempt to check the facts he made a false and defamatory allegation. His failure to particularize, to name any specific person, cast a shadow over many people. The circumstances disclose that there was no unlawful or improper suppression of the investigation, the evidence or the inquest in relation to the death of Arthur Magee.

DISCRIMINATION

The sole issue in this matter involves an allegation made by Dr. Shulman that the Government of Ontario and certain senior civil servants of the Department of the Attorney General discriminated against persons in relation to their appointments as coroners on the basis of race, creed, colour, nationality, ancestry or place of origin. The focal point of this controversy centred on an application made by Dr. George Sereny, a Canadian of Hungarian extraction, to be appointed a coroner for the County of York. The matter first arose on March 22, 1966, when Dr. Shulman, then Chief Coroner for the County of York, received the following letter from Dr. Sereny:

> "I would like to apply for a part-time Coroner's position. My training briefly is as follows: Graduated, 1950, in Munich, West Germany. Emigrated to Canada in 1951. Junior internship 1951-1952. Wrote my L.M.C.C. in 1952. 1952-1956 Post-Graduate in internal medicine in Kingston, London and Toronto, Ontario. I received my certificate in internal medicine in the fall of 1956. Since that date I have been practising internal medicine and been doing research in alcoholism from 1961 to date. I hope you will find the foregoing satisfactory." [Exhibit 169]

After questioning a number of specialists in internal medicine Dr. Shulman wrote to Dr. Cotnam on March 23, 1966, enclosing Dr. Sereny's letter and stating:

> "I know Dr. Sereny to be a very conscientious doctor, presently spending a great deal of his time in medical research with a special emphasis on alcoholism. I believe that he would be a very worth-while addition to the Coroner staff.
>
> You are of course aware that with the new amendment to the Coroners Act there will be an increase of approximately one, or even possibly two thousand cases in this coming year, and we could very easily use another coroner in the central area. I hope that you will see fit to second my recommendation of his appointment.
>
> At the end of this year we will of course be losing Dr. Evelyn's service and Dr. Sereny would make an excellent replacement for him." [Exhibit 171]

On April 15, 1966, Mr. Hills acknowledged Dr. Shulman's letter, requesting him to hold the matter in abeyance pending the outcome of Bill 47 which was then under consideration by the Legislature. [Ex. 172]. In reply to Mr. Hills, Dr. Shulman wrote to him on April 17, 1966, stating:

> ". . . I must point out to you that we are having extreme difficulty in servicing certain areas of the city at the present time. This problem is going to become more acute in the summer and may very well reach crisis stage by September.
>
> According to my estimates we are going to have an additional load of up to 200 calls a month beginning this September. Rather than wait until we are in serious difficulties I would request that you assist us.
>
> Dr. Sereny's appointment would be a great asset to the office because his research background would be of invaluable assistance to us." [Exhibit 173]

Subsequently, in the early part of June of 1966, Dr. Shulman telephoned Dr. Cotnam to ask him the cause for the long delay in the appointment of Dr. Sereny. According to Dr. Shulman, Dr. Cotnam answered that he did not know but that he had forwarded all the information to Frank Wilson, the Deputy Assistant Attorney General. On June 7, 1966, Dr. Shulman contacted Mr. Wilson to question him about Dr. Sereny's appointment. Dr. Shulman testified that during the course of the conversation, Mr. Wilson asked him how to spell Dr. Sereny's name, his nationality and where he lived. Dr. Shulman told him that Dr. Sereny was a Canadian of Hungarian extraction and that he lived in North Toronto where a coroner was needed. Mr. Wilson then replied: "Don't they all have to live in West Toronto?" [Page 2582 lines 19-29]. Dr. Shulman testified that his relations with the Attorney General's Department were very delicate and he did not want to have another fight with them, so he passed this over. [Page 2582 line 30 to page 2583 line 2]. Dr. Shulman then urged Mr. Wilson to expedite the appointment, whereupon he said: "Some people's appointments take longer than others." [Page 2583 lines 6-7].

Mr. Wilson agreed that this conversation took place but denied asking about Dr. Sereny's nationality. [Page 2669 lines 3-6]. Dr. Shulman's version of the conversation was corroborated by the testimony of his secretary, Mrs. Worobec, who testified that she listened to the conversation on the extension and afterwards made some shorthand notes of it. [Page 2758 line 28 to page 2760 line 5]. Dr. Shulman agreed that Mr. Wilson often has a peculiar way of expressing himself and volunteered that Mr. Wilson was known as "the quipster of the Attorney General's Department". [Page 2608 lines 29 and 30]

On September 15, 1966, Dr. Shulman again wrote to Dr. Cotnam, stating:

> "For many months I have been trying to hurry George Sereny's appointment as a coroner in North Toronto.
>
> Today I am very sorry to inform you that because of ill health, Dr. Murray Rotstein has informed us that he will be unable to accept any further calls for the foreseeable future, and possibly permanently.
>
> If we are to continue to give adequate service to all parts of Metro I must have a replacement for Dr. Rotstein. Dr. Sereny is well qualified and is anxious to do the work. Would you please do whatever is possible to hurry up this appointment." [Exhibit 174]

Dr. Shulman failed to receive a reply from Dr. Cotnam and on November 9, 1966, he again wrote to him requesting that he look into the matter. [Ex. 175]. Subsequently, on November 30, 1966, Mr. Hills replied to Dr. Shulman assuring him that the Supervising Coroner's Office was aware of the situation and that steps were being taken to remedy it. [Ex. 176]. Later, on December 15, 1966, Dr. Shulman wrote to Attorney General Wishart, stating:

> "Since last March I have been attempting to fill a vacancy for a coroner in North Toronto, which has become aggravated by the retirement of one man and which will become more serious by the imminent retirement of another. I have recommended the appointment of Dr. George Sereny, a highly qualified research scientist on the staff of the Sick Children's Hospital. Dr. Sereny would be an excellent addition to our staff as his qualifications

are so outstanding. He has done considerable original research in the field of alcoholism and has published numerous papers in many medical journals.

In June I phoned Dr. Cotnam to inquire why there was such a delay and he informed me that the application had been forwarded to your department. I then spoke to Mr. Wilson, who made certain upsetting comments about Dr. Sereny's nationality (he is a Canadian of Hungarian extraction) and informed me that, 'Some person's applications take much longer to process than others'.

I did not wish to make an issue of these rather unfortunate remarks because I was hopeful that the appointment would ultimately be made, and I have had more than enough controversy for one lifetime. However, by September as I had heard nothing I wrote again to Dr. Cotnam on this subject but received no reply.

Last month I again wrote to Dr. Cotnam and received an answer from Jack Hills indicating that the matter was being looked into.

I am sorry to have to trouble you about this matter, but it has dragged on for close to a year and it now has become urgent." [Ex. 177]

By letter dated January 9, 1967, Attorney General Wishart acknowledged receipt of Dr. Shulman's letter advising him that since there were many aspects to consider in the appointment of a person to this important position, the matter was under active consideration, and assuring him that an appointment was to be made in the very near future. [Ex. 178]

On February 6, 1967, Dr. Shulman was informed that Dr. Ross Bennett had just been appointed a coroner. [Page 2589]. The next day Dr. Shulman wrote the Attorney General, stating:

"I have indirectly been informed of the appointment of Dr. Ross Cameron Bennett as a coroner. As Dr. Bennett both works and resides in the extreme east end of Toronto, an area which is already well serviced by coroners, I can only suggest that when a vacancy occurs in the area, I will be delighted to put Dr. Bennett to work. In future, inasmuch as Metro coroners must work on my staff, I hope it does not appear unreasonable to request that I be consulted before appointments are made. This would avoid today's situation in which a lesser qualified man is appointed to an area where there is no need for a coroner, while another area remains unserviced.

It is now one year since I applied to have a coroner appointed to fill the vacancy in North Toronto. Dr. Bennett informs me that he was approached one month ago by Mr. Jack Hills to take this post. The doctor whom I had suggested to fill the North Toronto vacancy has a background in research and has published many papers in several medical journals. Dr. Bennett has done no research and has not published a single paper.

I find this series of events very disturbing, and I request that you give it your early attention." [Page 2591 line 7 to page 2592 line 10] [Ex. 179]

Dr. Shulman testified that he was quite upset at this point and thought he should go higher. He went to see Mr. Kinmond, the press secretary of Premier Robarts, and gave him a copy of the correspondence. He then wrote a letter to the Attorney General, dated February 15, 1967, as follows:

"This matter has now dragged on for a year and has become urgent.

I hope that this will not seriously upset you but in an effort to have some action taken I have given a copy of the facts to Mr. William Kinmond at the Premier's office in the hope that he can be of assistance.

Again I wish to point out to you that it was last March when I originally wrote to your Department about the coming vacancy in North Toronto and requesting that an appointment be made."

Thereafter, on February 23, 1967, Dr. Shulman learned that Dr. Cranston had been appointed a coroner and on the same date he delivered the following letter to the Attorney General:

"Following our recent correspondence and particularly my letter of February 7th, 1967, I find it almost unbelievable to learn this morning that you have appointed another coroner for the extreme east end of Toronto, a Dr. Cranston.

In order to maintain the interest and high quality of service given by our coroners, it is essential that they receive sufficient work to make it worth their while. Just recently Dr. Peter King, one of the Scarborough coroners, has arranged to sever his east Toronto hospital connections in order to better service the area. There is absolutely no work available for these new men you have appointed.

I find it fantastic that these appointments should be made when I have been requesting for a year the appointment of Dr. George Sereny in North Toronto—a much higher qualified man and an area in which there is no coroner at all.

Once again my request that you give this your personal attention." [Ex. 181]

The last correspondence in this series was written by the Attorney General to Dr. Shulman on March 6, 1967, in which he stated:

"This letter will confirm that following our interview at my office of a few days ago, I have directed a study of the situation respecting the number and location of coroners in Metropolitan Toronto, and your request for one specific appointment.

I am aware of the reasons why this appointment has not been made.

I am presently engaged with my estimates in the Legislature, but as soon as this matter is completed I shall be in touch with you either by letter or by telephone to discuss the subject matter of your recent letters." [Ex. 182]

Dr. Shulman alleged that the reason Dr. Sereny was never appointed was due to discrimination. As support for this allegation, Dr. Shulman recounted during his examination that while he had been Chief Coroner, he had recommended five men for the position of coroner. He said there was never any problem with the ones who were Anglo-Saxons, but the ones who were not Anglo-Saxons were not appointed. [Page 2600 lines 15-20]. A somewhat similar statement was reported in the press following his dismissal:

"Dr. Shulman said during his term of office he submitted five recommendations for new coroner appointments. The three non-ethnics were appointed. The two ethnics were not." [Page 2600 line 30 to page 2601 line 4]

Cross-examination of Dr. Shulman disclosed that Dr. Gollish was one of the "non-ethnics" referred to and that Dr. Gollish withdrew his application after Dr. Shulman suggested that he drop his staff appointment at East General Hospital. Dr. Gollish preferred to withdraw as a coroner rather than withdraw from the staff of the hospital. [Page 2601 lines 13-25]

The other "ethnic" referred to by Dr. Shulman was Dr. Sereny.

Dr. Shulman testified that he had repeatedly been told by Dr. Cotnam that in some areas there was often grave difficulty getting coroners and they would take even Hungarians, but in Toronto, where the appointment was very important and there was a shortage of coroners, their policy was to appoint only Anglo-Saxons. [Page 2604 lines 8-23]. Dr. Shulman offered as further evidence of discrimination a letter, dated May 25, 1960, written by Dr. Smirle Lawson, formerly Chief Coroner, in reply to a query by Mr. Eric Silk regarding the nature of work performed by a coroner named Dr. Lore. The letter read:

> "Dear Eric:
>
> We felt that many well-to-do families with a death in their home might resent being questioned by Dr. Lore, a Chinese. Therefore, we made a rule that all Chinese coroners' cases be assigned to Dr. Lore. Of course, how many cases he will handle is impossible to say."

Dr. Shulman stated that Dr. Lore never received any assignments, except one which he refused, and that prior to his death, Dr. Shulman had investigated six Chinese deaths. Dr. Lawson resigned on June 1, 1962. Both Dr. Lawson and Dr. Lore are now dead, so cannot testify as to the circumstances that brought about the letter and the procedures adopted thereafter. The evidence suggests that Dr. Lore was a very ill man for some time before his death in 1962 and this may have had some bearing on the number of cases assigned to him, and for the assignment of Chinese cases to other coroners. However, the suggestion that a physician of any racial origin should be excluded from inquiry into cases of any segment of the community does not commend itself to me, is contrary to my view of what is proper, and as well, is against the spirit of the Ontario Human Rights Code. The evidence of Dr. Shulman together with that of Dr. Cotnam and Mr. Hills clearly establishes that there has been no discrimination in respect to the manner of allocating work since 1962. There is some doubt in my mind whether this last matter relating to Dr. Lore falls within the Terms of Reference of this inquiry as it involves the distribution of work to a doctor who was already a coroner, rather than discrimination in relation to the appointment of a coroner. The fact that Dr. Lore was appointed indicates that there was no discrimination against him in relation to his appointment.

The accusation of discrimination in relation to the appointment of coroners was vehemently denied by Dr. Cotnam, Mr. Hills, Mr. Dick and Mr. Wilson. According to Dr. Cotnam there were several factors upon which his initial decision not to recommend Dr. Sereny was based, none of which had anything to do with Dr. Sereny's nationality. Apparently this determination had been made before May 18, 1966, when Mr. Hills forwarded all the information on Dr. Sereny, without a recommendation for appointment, to Mr. Wilson. The first consideration was whether there was any need for a coroner in central or north Toronto as suggested by Dr. Shulman. Since there had been no complaints of overwork or of poor service, and notwithstanding an increase in the volume of work as a result of the new legislation, Dr. Cotnam stated that as far as he was concerned there was no need to appoint a coroner for this area. [Page 2731 lines 6-12]

It was the opinion of Dr. Cotnam that Dr. Sereny would be unsuitable as a coroner because he was chiefly involved in medical research and it was the policy of his office to appoint general practitioners whenever possible. He believed that general practitioners make better coroners. Apparently, it was the view of the Supervising Coroner's Office that general practitioners were more familiar with the community and were better equipped to deal with people. [Pages 2733 lines 1-25]. Further, Dr. Cotnam believed that general practitioners maintained their interest in the job and were usually more readily available than specialists. [Page 2745 lines 19-23]. If an occasion should arise where an expert's opinion was necessary, such as an alcoholic problem, Dr. Cotnam felt that specialists like Dr. Sereny would be more helpful as consultants or expert witnesses. None of these considerations was mentioned by Dr. Cotnam when Dr. Shulman asked him for the reason for the delay in the appointment. Had Dr. Cotnam given these reasons to Dr. Shulman in June of 1966, the subsequent allegation of discrimination might have been avoided.

Subsequently it came to Dr. Cotnam's attention that Dr. Shulman was proposing a series of specialist coroners. This was not until about November of 1966. Dr. Shulman sent out a memo in this regard to all coroners in Metropolitan Toronto but excluded Dr. Cotnam. One of the coroners forwarded a copy of the memo to him. Dr. Cotnam testified that he didn't believe in specialist coroners, that is, coroners who carry out one type of investigation. Such a coroner could not be restricted to any one area, and some types of accidents occur more frequently than others. For example, if a specialist coroner looked after all the fatal motor vehicle accidents in 1966 in Toronto, he would have been doing 68% of all the inquests.

Dr. Cotnam testified that by the spring of 1966 his relationship with Dr. Shulman had something to do with his hesitation to make a recommendation of Dr. Sereny. He stated that for four years they had disagreed on many things. Any disagreement with Dr. Shulman resulted in an immediate blow-up, either in the press or otherwise. During this period of time he had come to a point where he did not always trust Dr. Shulman's judgment and opinion and he felt that anything Dr. Shulman suggested had to be carefully checked out before any decision was made. He stated that the fact that Dr. Sereny was a Hungarian had nothing to do with his not recommending his appointment. He did not know Dr. Sereny's nationality at the time and harboured no ill feelings against Hungarians.

Mr. Hills testified that it was his responsibility to find coroners where they were needed. Of the three coroners appointed in Metro in 1966, all were recommended by Dr. Shulman. The two appointed in 1967 were found by Mr. Hill and recommended by him. He did not consult with Dr. Shulman on either. Dr. Shulman could recommend the appointment of coroners, but the Attorney General need not accept his recommendation. Mr. Hills testified that when Dr. Sereny's application for appointment came to Dr. Cotnam's office on March 23, 1966 there was absolutely no discrimination in this province with respect to coroners' appointments by reason of race, creed, colour, nationality, ancestry

or place of origin. This has never been a factor in the appointment of a coroner, Mr. Hills added.

Mr. Hills stated that when Dr. Sereny's letter of application was received he made certain inquiries. He learned that Dr. Sereny was employed as a research physician. He was so listed in the Canadian Medical Directory. He did not feel that a full-time research man would make a good coroner, and later told Mr. Wilson he didn't want a research physician appointed. When he sent on Dr. Sereny's application he did so without a recommendation. Usually he would recommend or not. This was the first time he had sent on an application without a recommendation for or against. When asked why, he answered: "I thought it was time the Department fought Dr. Shulman rather than our end." [Page 2720 lines 10-14]. He later learned that Dr. Sereny had received a part-time appointment as a Crown employee to the Alcohol and Drug Addiction Foundation on July 1, 1960. This organization receives provincial funds and is an institution for which the Minister of Health is responsible in the Legislature. In October of 1964 Dr. Sereny became a full-time employee of the Alcohol and Drug Addiction Foundation and was so employed at the time of his application. Mr. Hills said that he received no ruling from the department on the application and did not notify the applicant as to whether his application was accepted or rejected. This was not his decision or responsibility.

After Dr. Shulman made his allegation of discrimination, Mr. Hills was asked to make a study throughout the province of various recent appointments of coroners who were not Anglo-Saxon. At the inquiry he gave the names, races, dates of appointment and places of appointment. I do not think I need repeat the names here, but the list showed the appointment of persons of Czechoslovakian, Egyptian, Hungarian, Haitian, North American Indian, German, Austrian and Jewish origin. The religious denominations and racial origins of the coroners then in Metropolitan Toronto were pretty well varied.

Mr. Rendall Dick, Q.C., the Deputy Attorney General, stated that applications for the appointment of coroners generally have to be approved by Dr. Cotnam, Mr. Wilson and the Inspector of Legal Offices before they come to him for approval. Most are generated by Dr. Cotnam and Mr. Wilson and as a result they have knowledge of the applicant. If they have no knowledge of the applicant and have to look into the matter, this checking takes more time. If there is not agreement as to the appointment's being reasonable and proper, it then becomes a matter for discussion, meetings and correspondence.

The application was made in March of 1966 but Mr. Dick had nothing to do with the matter until a year later. During the period of time when this application was pending, the department, in consultation with the Supervising Coroner, was considering generally the whole question of the appointment of coroners. He was also aware of a controversy between Dr. Shulman and other persons in the department respecting appointments. So far as he was concerned the reason for not appointing Dr. Sereny was that he was already a full-time salaried employee of an agency of the Ontario Government, and secondly that he was a specialist in alcoholism, a qualification that would be most helpful as an

expert witness at a coroner's inquest, but not a qualification which was particularly suitable to a coroner. Normally it is the Supervising Coroner who recommends appointments. In this case the Supervising Coroner never recommended the appointment of Dr. Sereny. As a result he never received the application or a recommendation to pass on to the Attorney General for consideration.

The Deputy Attorney General stated that his own view was that Dr. Shulman's suggestion that Dr. Sereny was not appointed because of his racial origin was ridiculous. Up until this allegation was made by Dr. Shulman, they never had had cause to look at the ethnic origin or nationality of any applicant. It was only after Dr. Shulman made his allegation that the Department had to acquire this information to answer it.

One point which clearly emerges from the evidence is that working relations between Dr. Shulman and the Department of the Attorney General were far from harmonious. This is borne out by Mr. Hills' explanation for his refusal to recommend Dr. Sereny: he said it was time the department fought Dr. Shulman rather than his end; by Dr. Cotnam's testimony that he no longer trusted Dr. Shulman's judgment and because of their poor relationship, he hesitated to recommend Dr. Sereny; and by Dr. Shulman's evidence that his relations with the Attorney General's Department were in a delicate state. There was a great deal of acrimony and discord between Dr. Shulman and Dr. Cotnam. I doubt very much, by reason of that animosity, that Dr. Cotnam at that time would have recommended for appointment anyone suggested by Dr. Shulman.

Counsel for Dr. Shulman submitted that the evidence showed that Dr. Sereny was discriminated against in relation to his possible appointment as a coroner by reason of his ethnic origin. If Dr. Sereny was already a full-time employee of a government institution, it could hardly be said that the government discriminated against him because of his race. Mr. Wilson may have been indiscreet in his comments, but I am satisfied that had Dr. Cotnam recommended Dr. Sereny, Mr. Wilson would have passed along the application and recommendation for approval, without regard to the applicant's race. There was no evidence before me that Dr. Cotnam ever considered Dr. Sereny's race or discriminated against him because of it. I am satisfied that in exercising his discretion to recommend or not to recommend Dr. Sereny as coroner, Dr. Cotnam did not discrimate against him on the basis of his race, ancestry or place of origin.

WASTE

The Terms of Reference require me to inquire into and report upon allegations made by Dr. Morton P. Shulman of the Municipality of Metropolitan Toronto that the Government of Ontario and certain senior civil servants of the Department of the Attorney General for Ontario, or any of them, wasted public funds by improper administration under the amendments in relation to the Schedule of Fees and the provisions of Section 21 of The Coroners Act, Revised Statutes of Ontario, 1960, Chapter 69.

Counsel for Dr. Shulman submitted that the Terms of Reference did not cover the allegations made by Dr. Shulman: allegations of a waste of the public's money in connection with mandatory investigations, in connection with fees, and in connection with cremations. [Page 2882 lines 7-27] I permitted him to adduce evidence in respect of each of these matters and tried to explore each allegation.

Dr. Shulman produced certain correspondence between himself and the Attorney General. He testified that he learned that various counties were upset about the amendments to the Act and the cost to them and sought his aid to prevent the amendments going into force. He then wrote a letter dated April 12, 1966, addressed to The Honourable Mr. Wishart, Attorney General, which reads:

> "Dear Mr. Wishart:
>
> You may not be aware that there has been considerable anxiety about the amendments to the Coroners Act among a number of municipal officials both from Toronto and other areas.
>
> From my estimate it would appear that there is going to be an increased expense of close to $10,000.00 a month in Toronto alone, and it would appear that the extra thousand plus cases which we will be investigating will be all normal ones.
>
> If I can be of any assistance to you I will be glad to discuss this matter with you at your convenience."

Mr. Wilson, Assistant to the Deputy Attorney General, replied to the letter on May 5 as follows:

> "This will acknowledge receipt of your letter of April 12th to the Attorney General.
>
> Upon receipt of your letter this matter was again reviewed with great care and consideration and it would appear that the amendments to the Schedule of Fees passed by the Legislature this Session will not be an inordinate increase on responsible authorities, having regard to the essential services which these fees enable the citizens in the province to enjoy."

This correspondence was obviously referring to the proposed amendments to Section 21 of The Coroners Act. Dr. Shulman testified that because of these new

amendments, every death in a nursing home would have to be investigated by a coroner, as well as every death in a hospital where a person had been transferred from a nursing home. He felt this was unnecessary. Dr. Shulman said that this also meant that the number of coroners would have to be increased to look after the increased number of investigations.

The amendment to Section 21 came into force on September 1, 1966.

Prior to the amendment the section read:

Where,

(a) an inmate in a home for the aged to which The Homes for the Aged Act applies dies; or

(b) a patient in an institution to which The Mental Hospitals Act applies dies,

the officer in charge shall immediately give notice of the death to a coroner and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he is of opinion that an inquest ought to be held, he shall issue his warrant and hold an inquest upon the body. [R.S.O. 1960, c.69, s.21]

After the amendment, Section 21 read:

Where a person dies while resident or an in-patient in,

(a) a charitable institution as defined in *The Charitable Institutions Act, 1962-63*;

(b) a children's boarding home as defined in *The Children's Boarding Homes Act*;

(c) a children's institution as defined in *The Children's Institutions Act, 1962-63*;

(d) a hospital under *The Children's Mental Hospitals Act*;

(e) a home for the aged to which *The Homes for the Aged Act* applies;

(f) a home for retarded children as defined in *The Homes for Retarded Children Act, 1962-63*;

(g) a hospital, institution or home established or approved under *The Mental Hospitals Act*, or a detention unit, examination unit or observation unit in a public hospital approved under that Act;

(h) a nursing home to which *The Nursing Homes Act, 1966* applies;

(i) a sanitarium as defined in *The Private Sanitaria Act*;

(j) a public or private hospital to which the person was transferred from a hospital, institution or home referred to in clause (a) to (i),

the person in charge of the hospital, institution or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he is of the opinion that an inquest ought to be held, he shall issue his warrant and hold an inquest upon the body. [1966, c. 27, s. 6]

Dr. Cotnam stated that this expansion was promoted from his office and he thought it excellent legislation. This legislation was prepared after consultation with the Attorney General's Department, the Department of Health, the Department of Welfare and the Legislative Counsel. All were in agreement that the amendments were necessary and good. Although the increase in the number of investigations increased the cost, he knew of no waste under the section.

The correspondence would indicate that Dr. Shulman put his views to the authorities for their consideration. They considered them and did not agree with him. No evidence was produced to indicate that following the amendments there was any waste in relation to them.

The Schedule of Fees dealing with coroners was also amended at the same time. Prior to the amendment the schedule read:

SCHEDULE A

Coroners

1.	For all services on an investigation	$15.00
	Where the investigation involves attendances beyond the place where the body is located, an additional	10.00
2.	For all services in connection with an inquest	25.00
	Where the inquest extends beyond two hours, for each additional two hours or part thereof	15.00
3.		
4.	For every mile necessarily travelled in connection with an investigation or an inquest	.10
5.	For expenses necessarily incurred in connection with an investigation or inquest, such expense allowance as is approved by the Crown attorney.	

After the amendment the schedule read:

SCHEDULE A

Coroners

1.	For all services on an investigation	$25.00
2.	For all services in connection with an inquest	25.00
	Where the inquest extends beyond two hours, for each additional two hours or part thereof	15.00
3.		
4.	For every mile necessarily travelled in connection with an investigation or an inquest	.10
5.	For expenses necessarily incurred in connection with an investigation or inquest, such expense allowance as is approved by the Crown attorney.	

The amendment to Schedule A provided a block fee of $25 for all services on an investigation, whereas prior to the amendment the fee was $15 with an additional $10 where the investigation involved attendances beyond the place where the body was located. Dr. Shulman thought this $25 was a very generous sum and that most general practitioners that he knew could not earn this much in their offices in the same amount of time they spent on an investigation.

Dr. Shulman was referred to a letter which he wrote to the Attorney General on March 2, 1966:

> "Yesterday I had the pleasure of examining the amendments to the Coroners Act and on behalf of the coroners I wish to thank you for revising their salary schedule.

I wish to point out to you however that when the amendment comes into effect my income from the coroners office will be less than that of each of the 18 coroners that work for me even though these gentlemen only are required to give one or two hours per day.

It is humiliating for me to have had to bother you so many times and if it is your intention not to revise my salary I would appreciate your letting me know. I assure you that under those circumstances I would not mention this matter to you again."

Regarding this letter Dr. Shulman was questioned and he replied as follows:

Q. In any event, in your letter of March 2nd, 1966, it is fair to say that there is no complaint about the amendments to The Coroners Act?

A. No, it is quite true sir. [Page 2941 lines 1-4]

Dr. Shulman was asked why, if he was opposed to the increase, did he write the letter to the Attorney General thanking him, and he replied that he wrote that particular letter to get a raise for himself. [Page 2958 lines 17-22].

Dr. Shulman wrote to the Attorney General on May 11, 1966, as follows:

"Dear Mr. Wishart:

Mr. Wilson was kind enough to send me a reply to my letter on this subject.

Of course we all wish 'the citizens in the province to enjoy essential services', however, I am sure that we also agree that we do not wish to have duplication of services and unnecessary wastage of money. To give one specific example—over 25% of the calls on which we are sending coroners to sign cremation certificates are duplications of calls which coroners have already investigated.

We certainly want every suspicious case investigated, but a great deal of money could be saved by eliminating the duplications and the unnecessary investigations of normal deaths.

If you would be interested in looking further into this matter, I would be glad to discuss it with you at any time."

Section 8 of The Coroners Act provides:

Where there is reason to believe that a person died in any of the circumstances mentioned in section 7, the body of the deceased shall not be embalmed or cremated and no chemical shall be applied to it externally or internally and no alteration of any kind shall be made to it until the coroner so directs. [R.S.O. 1960, c. 69, s. 8]

Dr. Shulman testified that approximately twenty-five per cent of all the cases in which coroners sign cremation certificates under Section 8 have already been investigated by coroners as ordinary investigations. He said that in those cases there was needless duplication and waste of money.

Section 8(a) provides:

Shipment of bodies outside Ontario

(1) No person shall accept for shipment or ship a dead body from any place in Ontario to any place outside Ontario unless a certificate of a coroner has been obtained certifying that there exists no reason for further examination of the body.

Fee for certificate

(2) An applicant for a certificate under subsection 1 shall pay to the coroner such fee as is prescribed by the Lieutenant Governor in Council by regulation.

Embalming, etc., prohibited

(3) No person who has reason to believe that a dead body will be shipped to a place outside Ontario shall embalm or make any alteration to the body or apply any chemical to the body, internally or externally, until the certificate required by subsection 1 has been issued. [1966, c. 27, s. 3]

Dr. Shulman testified that in all cases of bodies shipped outside of Ontario, approximately twenty-five per cent of the examinations were duplications, and in his opinion this was also a waste of money. Dr. Shulman said that he had no objection to the amendment to Section 8(a), but his criticism was that it did not exempt cases which had already been investigated by a coroner.

He received no written reply to his letter of May 11 but did have a conversation with Mr. Wilson. According to Dr. Shulman, Mr. Wilson phoned him within a very few days after he sent his letter and said:

> "You are aware of course that cremation fees are not paid out of public funds, so we are not wasting public funds; we are wasting the public's funds."

Dr. Shulman testified that he replied:

> "Yes, that's true."

He further testified that Mr. Wilson then stated that he would pass the matter along to the Attorney General.

Dr. Shulman stated that on a later occasion, on February 7, 1967, he raised the matter with the Attorney General and Mr. Wishart replied that the amount of money involved was really not very much.

In those cases investigated by a coroner in which he decides that an inquest is unnecessary, the coroner gives a warrant for the burial of the body under Section 12 of the Coroners Act. In those circumstances, where the body is buried, there is afterwards an opportunity for exhumation if further inquiries warrant it. When the coroner signs the warrant for burial under Section 12 he might be required to sign a further certificate if he is later told that the body is to be cremated. Where a body is cremated there is no chance for future exhumation, so under Section 78 of The Cemeteries Act the coroner is required to certify that the cause of death has been definitely ascertained and there exists no reason for further inquiry or examination. The charge for this certificate is $10. Dr. Shulman's complaint is in regard to this extra fee which apparently has to be paid in approximately 25% of the cremation cases.

As to Dr. Shulman's suggestion that 25% of the bodies which were cremated had already been investigated by a coroner, and that to require a duplication was a waste of public funds, Dr. Cotnam testified that the number of cremations out of the total number of deaths was less than 4% and perhaps 25% of these have had a coroner's investigation, so that the true figure for consideration was

something in the neighbourhood of 1%. He pointed out that frequently at the time of the coroner's investigation no decision has been made by the family whether or not to have the body cremated. Therefore, a coroner, often a different coroner, has to be assigned to look after the matter. Even if it is the same coroner he still has to make an additional trip to sign a cremation certificate, under the Cemeteries Act, which is completely different from the one he originally signed under the Coroners Act.

Dr. Cotnam further pointed out that many of the bodies sent to Toronto for cremation come from outside the County of York. A certificate under the Cemeteries Act has to be completed in Toronto, even if there has been a previous coroner's investigation elsewhere. Dr. Cotnam stated that he personally signs about 10% of the cremation certificates in Toronto, many of which come from outside the County of York, and some from within Metropolitan Toronto. In each case the coroner must satisfy himself as to the cause of death. He may do this by telephoning the attending physician, the hospital or a coroner who has previously examined the body. He agreed that in a small percentage of cases there might be duplication, but pointed out that the two examinations did not take place at the same time and a second trip was required by either the same or another coroner. When this duplication occurred, as it did in approximately one per cent of the deaths, payment for the cremation certificate was charged to the family of the deceased person which had requested the certificate. He stated that it would be the exception where a coroner making his initial investigation knew that there was going to be a cremation.

Dr. Cotnam stated that he also recommended the amendment to Section 8(a) which relates to shipping certificates.

It would appear that in those cases investigated by a coroner, where cremation is desired or where a body is shipped outside Ontario, some duplication exists and this is charged to the family of the deceased. There is a difference of opinion as to whether such subsequent investigations are necessary. Certainly a different certificate is.

In argument, counsel for Dr. Shulman submitted that Dr. Cotnam, Mr. Wilson, Attorneys General Cass and Wishart wasted public funds by sponsoring amendments to the Coroners Act, requiring unnecessary work for which the public would pay. This is a matter of opinion and I am not called upon under the Terms of Reference to decide this, since to do so would be to question the wisdom of the Legislature. The Legislature having passed the amendments, they are now law. Counsel for Dr. Shulman further alleged improper administration in relation to fees payable to coroners, but no evidence in respect of this was adduced.

A further issue was raised during the inquiry relating to post-mortem examinations before cremation.

On March 27, 1963, Dr. Shulman wrote to Dr. Cotnam recommending that all cases requesting cremation, which have not been treated in hospital with a

definite diagnosis established, require the performance of a post-mortem before cremation. Dr. Cotnam replied on April 3, 1963, as follows:

"Subject: *Cremation cases.*

Thank you for your letter of March 27th regarding the above.

I will forward your recommendation to the proper authorities as you have requested, although my opinion in this matter does not coincide with yours as I stated previously.

However, I would ask you first to enlarge on your proposal and present it in more detail so that the proper authorities can appreciate all the problems involved in your suggestion particularly regarding facilities to do same and availability of pathologists and all costs involved, etc.

Also, what delay factor may be involved?—and have you approached and investigated the whole problem with all parties involved in such a scheme such as all Metropolitan hospitals, funeral directors and crematoria and, of course, all Metropolitan Toronto coroners?

Upon receipt of the above information, I will forward same, as you request, with my own personal comments.

I fully appreciate your concern in this matter and I agree certain changes are necessary regarding cremations and considerable thought and investigation has already been done regarding this situation through this office. I do not think the end justifies the means you suggest. I believe there is a more practical solution to the problem for all concerned after thorough discussion and consideration by all parties involved. I do not think *a hasty decision* is desirable or necessary in such an important matter, and from my preliminary discussion and investigation I feel we can evolve a more practical solution than the one you have suggested, although your proposal should be given due consideration by all concerned.

I will forward your proposal to Mr. Cass, the Attorney General, and all your future pertinent correspondence, so he will be well informed re the problem.

Thank you for your interest and concern regarding this important matter." [Page 2929]

Dr. Shulman then wrote the following letter to Dr. Cotnam on April 5, 1963:

"*Re: Cremation cases*

Thank you for your letter of April 3rd. As you have suggested I am having further consultations on this problem with the authorities involved, and I certainly agree that a hasty decision is not necessary. I will be in touch with you further about this matter upon your return from England." [Page 2931]

Dr. Cotnam testified that he considered Dr. Shulman's recommendation regarding compulsory post-mortem examinations before every cremation and did not agree with it. However, he asked Dr. Shulman to put his views in writing and forwarded Dr. Shulman's letter along with a covering letter expressing his own views to the Attorney General. Dr. Cotnam felt the proposal would be extremely expensive and in his opinion it was unnecessary to do an autopsy in each case. No change was made in the law.

Dr. Cotnam's memorandum to the Attorney General regarding this matter did not mention that he was enclosing Dr. Shulman's letter but Dr. Cotnam

stated that he did enclose it. He stated that his memorandum was made after talking to Dr. Shulman and contained Dr. Shulman's original proposal. Dr. Cotnam's comment in his memorandum regarding Dr. Shulman's proposal was:

> "I knew sir that we could expect some thoughtless and ill-conceived proposal from Dr. Shulman but I never dreamed of one so far left of centre as it were."

This letter was written by Dr. Cotnam on April 3, 1963, only two weeks after Dr. Shulman took office as Chief Coroner. It indicates that the animosity between these two men existed even then; but it has nothing to do with any waste of public money, and does not relate to the Terms of Reference.

SUMMARY

I have attempted to deal with each matter separately so that the individual against whom the allegation was made would have the opportunity to hear the allegation and to answer. Dr. Shulman gave evidence in relation to each of his allegations and was given the opportunity to call any witnesses he chose in support and to cross-examine witnesses called by others. Commission counsel called all other witnesses who were thought to have any information or knowledge of the matters in question. Because this was a hearing and not a trial, there was no onus on anyone to prove or disprove any allegation. After the evidence was concluded counsel for all interested parties were given the opportunity to make submissions. Commission counsel, quite properly in my opinion, made no submissions, but retired after the completion of the evidence.

During argument counsel for Dr. Shulman submitted that he did not intend to argue about allegations which he said were never made by Dr. Shulman and that he would not deal with the word "unlawfully" in the Terms of Reference.

Counsel for Dr. Shulman filed various newspaper clippings as exhibits to show what his client had said before the inquiry. However the position Dr. Shulman took at the inquiry is quite clear. He was asked the following question and made the following answer:

Q. Are there cases in Metropolitan Toronto during the period of time in which you were the Chief Coroner of Metropolitan Toronto—

A. Yes, sir.

Q. —in which there has been an unlawful or improper suppression of an investigation or inquest?

A. Yes, sir. [Page 592 lines 19-26]

Dr. Shulman then listed the cases, giving the name of the deceased and the person or persons against whom his allegation was made. As a result, all those cases were investigated and the Commission heard evidence on each. The allegations of "improper suppression of evidence, whitewash and cover-up" are all allegations which imply illegal conduct, since it is a criminal offence wilfully to attempt in any manner to obstruct the course of justice.

The submission by counsel for Dr. Shulman that he would not deal with the word "unlawfully" is therefore equivalent to an admission that he could not prove any unlawful conduct. Had Dr. Shulman made this admission at the start of the hearing considerable time and money would have been saved.

This Royal Commission was obviously appointed because of allegations of malfeasance touching upon the administration of justice, not because there was a difference of opinion as to the role of a coroner. The manner in which these allegations were expressed and the language used went far beyond a mere complaint as to the role of a coroner in our present system. They were specifically

and by implication allegations of malfeasance by public servants. The Terms of Reference required me to inquire into and report upon allegations made by Dr. Shulman that the Government of Ontario and certain senior civil servants of the Department of the Attorney General of Ontario, or any of them, unlawfully or improperly did certain things. I have attempted to do so.

My first impression was that Dr. Shulman used words carelessly. As the hearing progressed it became clear that this was not so. He is very glib and articulate. When he used the words "intimidated" rather than "frightened" in the Gualtieri inquiry, I am satisfied that he did so deliberately, well knowing that the word "intimidated" implied unlawful and improper conduct on the part of someone; the word "frightened" did not. There was not a shred of evidence that anyone tried to deter a witness from giving evidence by threats or violence. To suggest, as Dr. Shulman did, that there was no difference between the meanings of the words "intimidate" and "frighten" under the circumstances disclosed might have been an excuse to evade responsibility when the allegation was shown to be false, but I cannot believe that Dr. Shulman did not appreciate the difference.

In many instances the facts were not in dispute but Dr. Shulman, by exaggeration and choice of words, implied misconduct where the circumstances did not justify such an implication. Such phrases as "suppress evidence", "sweep under the rug" and "whitewash" all carry an implication of improper conduct. When he used such expressions I am satisfied he meant to imply that there was a misrepresentation by concealment of facts *that ought to have been made known.* Yet Dr. Shulman used this expression in reference to situations where evidence was withheld by legal officers under a rule of law. Inadmissible evidence *ought not to be disclosed* and objecting to its admissibility is not unlawful or improper.

Many of the allegations made by Dr. Shulman were merely suppositions. In such cases, when pressed for facts to support them, Dr. Shulman produced none. Such allegations were based only on suspicion. An example of this type was his accusation against Mr. Hills: "He is here to take away files to destroy them." When pressed for facts, he pleaded that he was misquoted, that he had said, "I *fear* they will be destroyed."

A close examination of other allegations indicates that he was presuming, not stating fact. He "presumed" there would be a mock inquest; he "supposed" there would be a whitewash. His presumptions carried implications which turned out to be false.

On one occasion in the Gualtieri case which related to a fire at the Workmen's Compensation Board Hospital he misstated the facts, then said: "The implications are obvious." Had he correctly stated the facts, no improper implication could have arisen.

On more than one occasion he based his allegations on information which he knew to be rumour. Subsequently the rumour turned out to be false. Such statements were irresponsible and unworthy of belief.

Many of Dr. Shulman's allegations were contradicted by previous statements either made by him, or with his authority, such as press statements, his Annual Reports and correspondence. When cross-examined as to such previous inconsistent statements Dr. Shulman complained that the commission counsel was not impartial and requested that I discharge him. It was the duty of commission counsel to inquire into the evidence and to bring out the truth. One way to test the truth of a witness' statement is to find out if on a prior occasion the witness told a different story. Dr. Shulman's evidence did not stand up to this test. For example the press release prepared by Dr. Shulman for Dr. Bunt in the George case [page 717 lines 3-7] which stated that Dr. Bunt, after consultation with Dr. Shulman, had decided not to hold an inquest was completely inconsistent with the allegation made before me that Dr. Bunt had been ordered not to hold an inquest. In his 1966 Annual Report Dr. Shulman said:

> "Every death in the last four years has been investigated openly and completely, with all the facts brought to the attention of the public in contrast to experience previously and elsewhere." [Page 588 lines 7-11]

This would cover the cases of George, Mulholland, Padoliak and Pisecny. Certainly this language is inconsistent with his subsequent allegations in these matters. Similarly, his letter of September 25, 1963 [Ex. 23] relating to Margaret Power, where he said he got advice from Mr. Common and followed it, is completely inconsistent with his subsequent allegation that Mr. Common refused to authorize an inquest. All these previous, inconsistent statements must be taken into consideration in deciding what weight should be attached to this evidence.

Some of Dr. Shulman's allegations were general in nature, without making specific allegations against any persons. Failure to particularize places many persons under a cloud of suspicion. To criticize public officials when they are wrong is in the public interest. To make vague allegations and insinuations against unspecified individuals is not. This smacks of McCarthyism, a technique repugnant to our sense of fair play and justice.

During the inquiry Dr. Shulman alleged in many cases that a particular physician was negligent or acted improperly. This Commission was appointed to inquire into allegations of unlawful or improper suppression of evidence or interference with inquests and, generally speaking, the issue of whether there was negligence between doctor and patient was not relevant.

Some allegations were based solely on Dr. Shulman's opinion and were made against persons who held contrary opinions. In deciding whether a particular coroner unlawfully or improperly suppressed an inquest, I had to consider such conflicting opinions. Even between highly qualified doctors opinions often differ and sometimes it is difficult to assert which of two is to be preferred. I have taken the position that I need not decide whether a particular coroner was correct or incorrect in the decision he made so long as I was satisfied by the evidence that he held an honest opinion, acted in good faith and was not improperly prevented or impeded from so doing by senior officials of the Department of the Attorney General. In deciding whether an opinion was bona fide, I took into consideration whether a similar opinion was held by others.

In deciding whether it was unlawful or improper suppression of evidence for a legal officer of the Crown to give an opinion as to admissibility, which prevented a particular witness from giving evidence, I had to consider conflicting opinion as to the law. Where Dr. Shulman's opinion differed from those of the law officers of the Crown, no witness was called by Dr. Shulman to challenge their legal opinion and there was no evidence whatsoever that the law officers of the Crown did not honestly believe that their advice was correct.

It may be that some of Dr. Shulman's remarks were made in anger, others for their political effect. This may explain them, but not excuse them. My commission was to inquire and report. I have set forth the facts as I found them and the conclusions I have drawn.